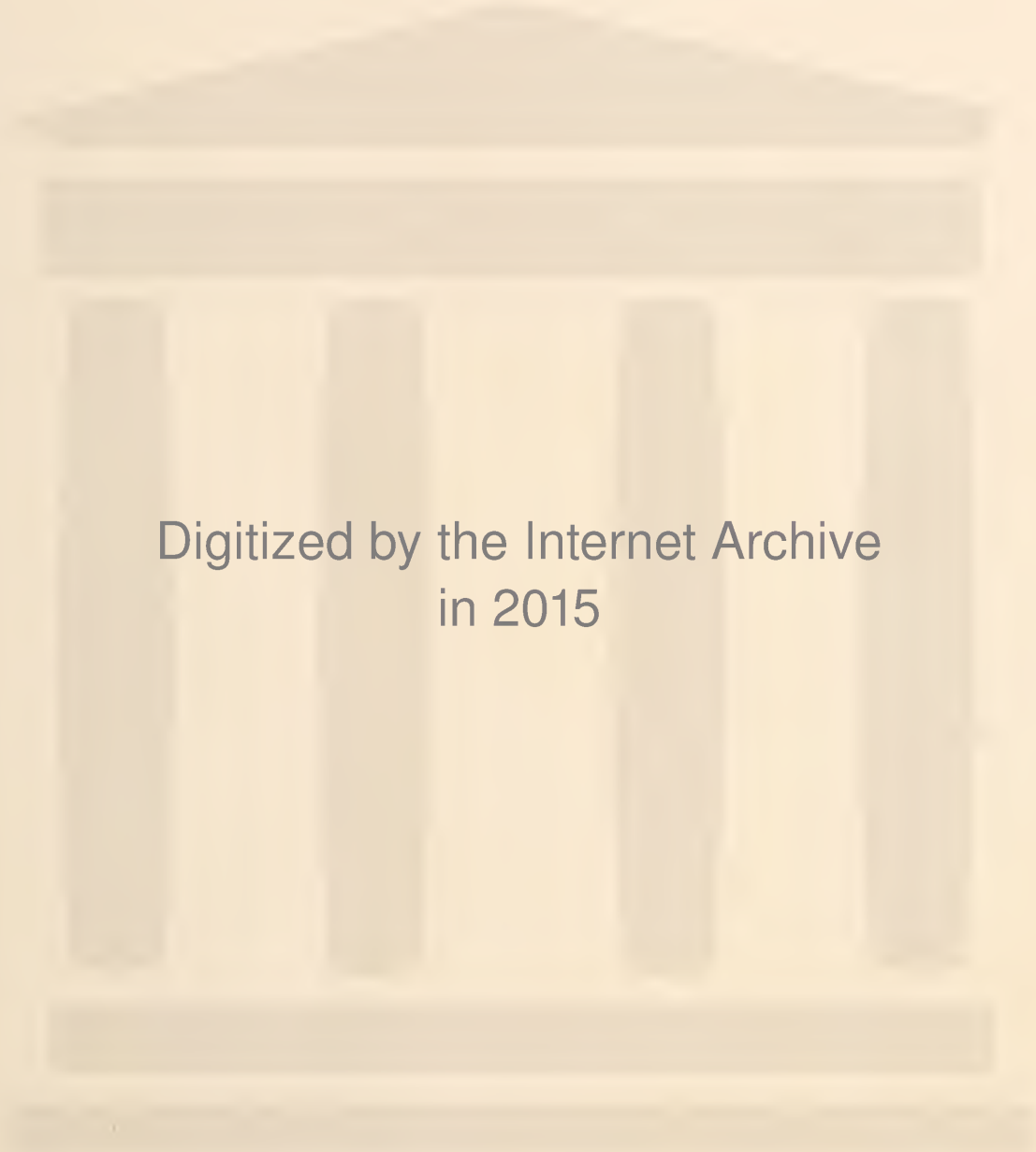
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Vol. XLVII - No. 1

THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

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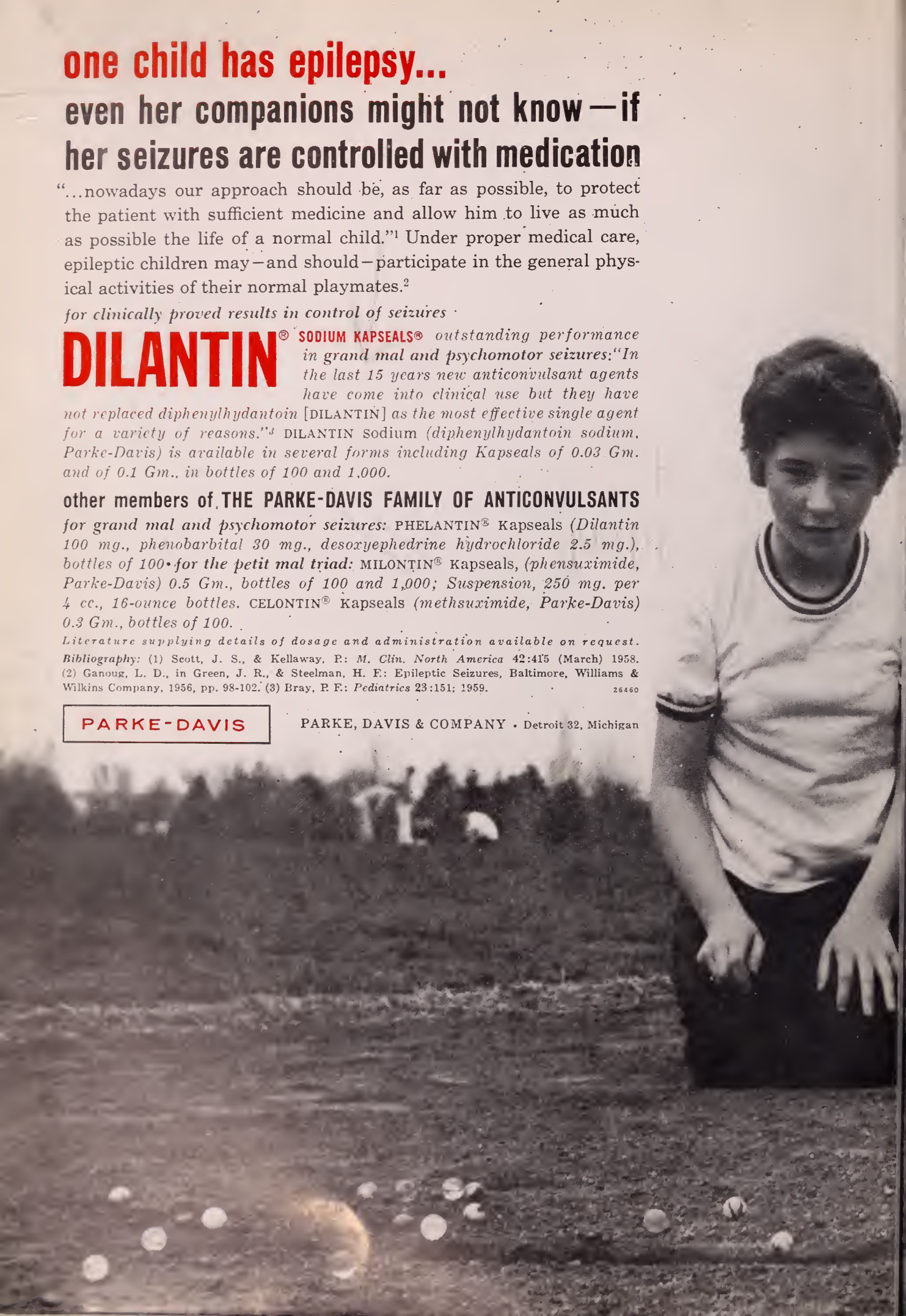
Literature supplying details of dosage and administration available on request.

Bibliography: (1) Scott, J. S., & Kellaway, P.: *M. Clin. North America* 42:415 (March) 1958. (2) Ganoug, L. D., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, pp. 98-102. (3) Bray, P. F.: *Pediatrics* 23:151; 1959.

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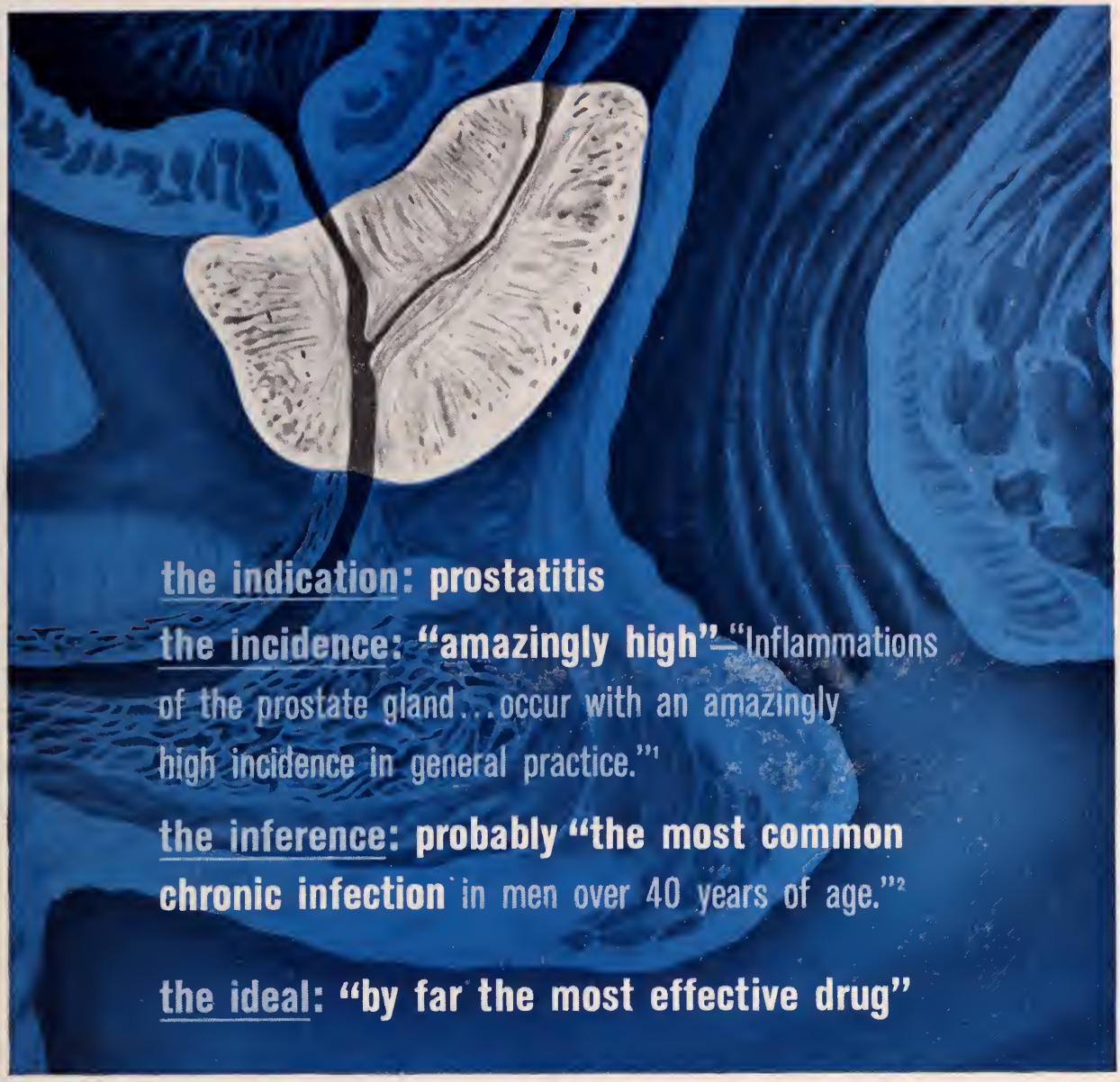
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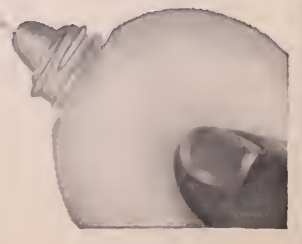
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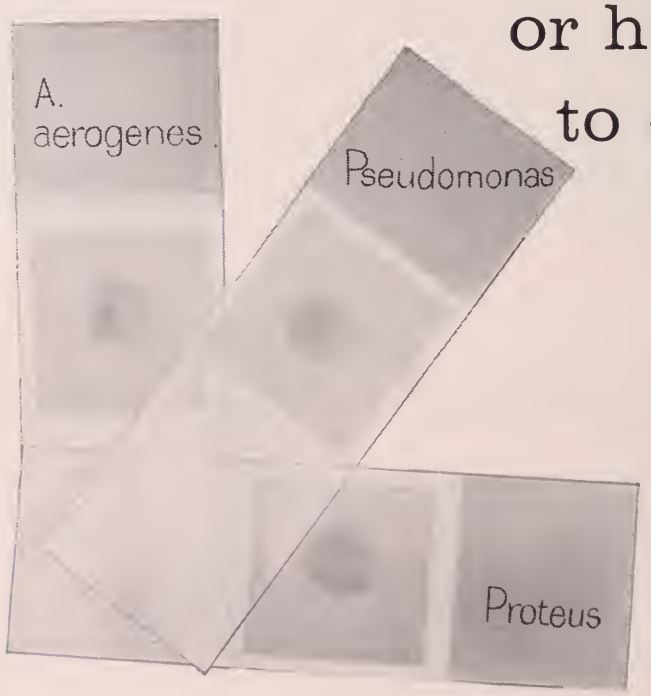
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1. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 2. Hirsch, H. A.; Kunin, C. M., and Finland, M.: **München. med. Wchnschr.** To be published. 3. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 4. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: **Ibid.**

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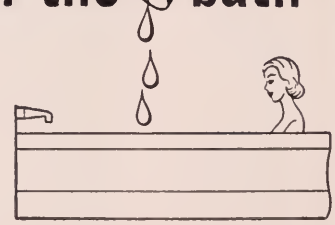
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1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

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1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

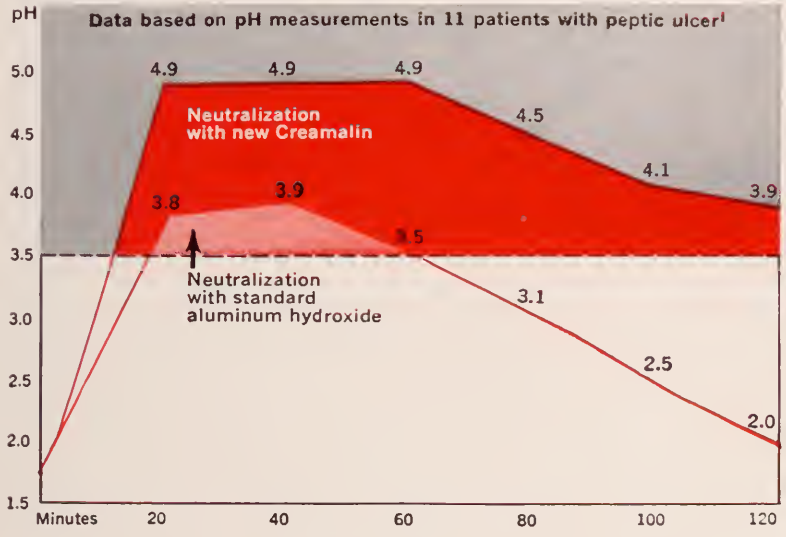


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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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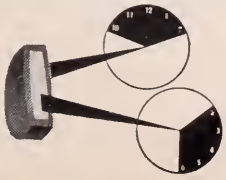
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THE JOURNAL
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Volume XLVII, No. 1, July, 1960

Advancements in Health, Education And Welfare

THE HONORABLE THOMAS B. CURTIS
MEMBER OF THE HOUSE OF REPRESENTATIVES
THE CONGRESS OF THE UNITED STATES
ST. LOUIS COUNTY, MO.

Dr. Jack and, I believe I should say, fellow Americans, it is a privilege for me to be here with this group of doctors and their wives and, I presume, many others who are interested in the health field. I always find it easy to talk to a group like this. Incidentally, I attended the Auxiliary's luncheon, and one of the themes that I heard before I had to leave there was the plight of the doctor's wife. Somehow, I got to wondering if that was peculiar to the medical profession because I had heard some of the complaints myself. One thing in particular, I recall. About a month ago my wife showed me a clipping from the newspaper which said that behind every smart man is a woman at home who keeps telling him how stupid he is.

My subject is the development of our health here in the United States. It is a subject that might cause you to wonder why a politician should be discussing it with those of you who know so much more about it, being in the medical profession. Perhaps the answer is this: As we all know, when we get too deeply involved in our own field, we sometimes lose sight of its relationship to other fields—the old expression that you lose sight of the forest because of the trees. Now, whether that is so or not, my observations will be made from the standpoint of one who has observed the field of health, the field that you are particularly concerned with, as it relates to many other fields, in particular how it fits into our over-all economy.

Certainly this, I think, I can state—and I think that the doctors throughout the country are aware this is so—that the future of health, the advancement in the field of health for our people in the United States, now is directly affected by what is or is not done through the governmental sector. And, I want to address myself somewhat to that.

Back about 400 B.C., the Greek civilization had reached an age we now call the Golden Age, from which we derive inspiration today because of the wisdom of the people in that society. I want to read a quotation from Thucydides, who was one of the great Greek scholars: "An island of relative affluence and political freedom in a sea of slaves and savages tends to succumb to the poisons in the sullied air even if it escapes the swords and arrows of the barbarians." Of course, Thucydides was referring to the fact that Athens in its Golden Age was this island, where, indeed, there were political freedom and relative affluence, but outside of her borders there existed seas, extending beyond any man's vision, of barbarism where there was not political freedom and where there was not affluence. This quotation, incidentally, was used in a book which I just finished reading— a very recent book by John Scott, who is assistant to the publisher of Time

U. S. Representative (R). Second District, Missouri, Member of the House Ways and Means Committee and of the Joint Economic Committee.

Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 9, 1960

Magazine. The title of the book is "Democracy Is Not Enough," and he is referring to the areas throughout the world, the seas where there is not this relative affluence and, certainly, there is not this political freedom. I think we well might pay attention to what poisons are in the air if we are going to preserve this little island—not so large an island when we consider the population, although we are now up to 180,000,000. This small island exists amid the masses throughout the world where there are not this relative affluence and this political freedom.

The Issue of Political Freedom

The first topic to which I would pay attention is this very issue of political freedom because other wise scholars from later days, I might say, not of Athens but of our early heritage in this country, only a meager, less than 200 years old, made the statement that liberty is attained only at the price of eternal vigilance. Or, as Thomas Jefferson said, "You cannot have a representative form of Government unless your people are educated." Or, as others have pointed out, if the people do not partake of their government, you can lose government of, by and for the people quite simply—by the people not paying attention. It will remain government for the poeple to some length—a longer time—but, when we abandon government *by* the people, I can assure you that government *for* the people soon goes down the drain. This relates to another question of today. I say this as one who has been in politics for a while, who are the people—who are the people?

From a politician's standpoint, the people are only those who are politically active, and therein lies an interesting thing. Who are politically active today? What is their attitude toward the definition of "Who are the people?" What is their idea of "What is citizenship?" Is citizenship simply a matter of government of, by and for the citizens? Or does the word "people" extend beyond those who have entrusted to them for a short period of time this precious right of voting and determining the destiny of a society? I say when one analyzes what "the people" includes, one, of course, realizes that it includes many, many people who cannot vote. So, citizenship is a trusteeship for those who do not have the vote. Everyone under 21 years of age cannot vote. Many of our older people, long since no longer active in our society's welfare but once part of the warp and woof of the active society, cannot vote. And, certainly, future generations cannot vote. So, I say, citizenship is a trusteeship.

We come back again to the point from a politician's standpoint—Who are the people? They are the people who are politically active. It is interesting to me today to notice that the group that is organized, the most efficient one, for political action is the group that is undertaking, in any way it can, to see that other groups do not get organized for political action as well. I am referring now to the COPE—the Committee on Political Education of the AFL-CIO, formerly the PAC—or the Political Action Committee of the AFL-CIO. This group is organized for political action and it undertakes action to see to it that any other group that might undertake to become organized for political action is discouraged from doing so.

Lest there be any question about that, I wish some of you would read, and many of you already have, the testimony before the Ways and Means Committee last July when we had under discussion in public hearings the Forand Bill. I refer in particular to the testimony and the interrogation of the representatives of the AFL-CIO, and I might say of Congressman Forand himself when the representatives of the American Medical Association were testifying. It caused me to raise the question for these gentlemen: Just what was their idea of smearing the medical profession and insinuating that if the medical profession organized for political action, it was doing something sinister and something improper? Indeed, my attitude is that I want to encourage every group that I can think of to become organized for political action. When Jimmy Hoffa and Harold Gibbons and Sydney Zagri—the three top men of the Teamsters Union, two of whom are living in my district and I represent them—said that they were going to purge me and purge some of my colleagues who dared to vote for the Landrum-Griffin Labor Reform Bill, many of my colleagues took exception to that. They also took exception to what Jim Carey, head of the International Electrical Workers Union, had to say when he remarked that he was going to do what he could to purge us.

My answer was not that of my colleagues at all, and herein lies the very basic message, I believe. My answer was, "I think you are doing just what you should do, Mr. Hoffa and Mr. Carey. You should organize to eliminate Congressmen like myself if you believe that we are not acting

in the interest of the United States as a whole and we are doing something detrimental to your organization. I urge you to organize, but at the same time I urge every other group of citizens to organize as well so that we can have real democracy in this country, so that the decision, when it is made, will not be made as the result of just one group that has learned to become politically active."

That is the situation to a large degree in politics today. Many people say: "Oh well, the Congress of the United States! Look at it. It has no intestinal fortitude." I have said it myself on the floor of the House about certain issues, and I feel it deeply on many issues. But, I remember one thing, and this is what our people should remember, too; if they do not like the looks of the Congress, remember that the Congress in essence is no more than a mirror that reflects back the image of the people who have taken part in political action, and, if they do not like the image, let them look back to Main Street in their own communities. Because, there is one trait that a long term Congressman seems to acquire. Either he is born with it, or he develops it. It is the strange knack of being able to reflect back what the people who are politically active think.

There are some Congressmen, though, who take a little bit different viewpoint of what the job of representation amounts to, and I want to express it because I think it is important. It is my attitude that a representative in Washington or a representative in the state legislature or a representative on a city council is selected more along the following lines—that people in any community can now devote only a certain amount of their time to government, and that is what we are talking about, because they have to follow their professions or their occupation. They have to be, or should be, paying attention to their families, to their churches, to their civic community work. Only a certain amount of time can they spend on politics or on government. So they select from their midst some one whom they ask to represent them and to find out—here is the key—to find out what the issues are and what the facts surrounding them are and then to vote on the basis, not of what the preconceived notions in the community might be, but upon the information that he has obtained and then report back, of course, to his people as to why he did what he did and what the facts were as he saw them. Now, of course, that is a more difficult course to take. The easier course is to keep your ear to the ground, try to figure out what the people are already thinking or what the pressure groups, already at work, have got the people thinking; ignore the facts, ignore the arguments and just vote in that fashion.

I am convinced that is not the kind of government that is really representative government; it is the kind of government that will eventually bring us to a halt and is illustrative of Thucydides' remarks, "The poison in the sullied air . . ." So, if our people will become active, I think they can be active in this fashion.

What Price Advancement?

Now, let me take this matter a step further, because I am going to talk about the development and advancement in the field of health in our great country. It is a strange thing to me that the very professions which have been responsible for the greatest achievements in health that any society in the history of the world has ever achieved, that those professions should be the very ones which are being smeared in our society and that our citizens are taught to believe these professions have no interest in the welfare of their fellow man. It is hard, perhaps, for doctors to believe that such a poison is in existence in our society because I think you will find that individually the people hold you in great respect. When people talk about their doctor, they talk about him with pride and affection. But collectively, the American Medical Association has a poor public image today and, as to where it comes from, it is hard to find out.

I, as a politician, can vouch for the same thing as a Congressman, an individual Congressman. I think that people tend to hold an individual Congressman in personal respect. I cannot say how much affection, but I think there is an element of personal respect, and yet as a group, the image of a Congressman or the image of a politician is something different; or even more sinister is the image of a lobbyist. As I use that term, in your own hearts there is a little bit of a shudder. Something a little bit sinister, and yet, lobbying is a good, fundamental part of representative government, so much so that we guarantee it in the Constitution, the right to petition the Congress. The reason I say it is an essentially good part is that the Congress, in order to legislate, must gather together what information and wisdom there is in the society and apply it to the problems of the day; and one of the greatest sources of its infor-

mation comes from the lobbying groups. The test, of course, is what are the techniques. If the techniques are poor, the particular lobbying might be. But the process itself is a fundamentally good process.

So, I come back to the point of this strange situation in the field of health, that the professions which have been responsible for the tremendous achievement of our society, an achievement that no other society in history or today matches, are the very professions that are bearing the brunt of this stigma. To put it another way, the fact that our people are living 10 years longer than they anticipated is largely the result of the tremendous work, of the tremendous advancement that has been made in the field of medicine, the field of drugs, the field of hospitalization techniques and nursing.

Yet, having kept people alive 10 years longer has created one of our great social problems. The people being alive 10 years longer, in most instances, have never anticipated that situation as far as their personal economics are concerned. And, we do face a problem of economics with our elder citizens.

Again I emphasize a good bit of that has come from the very advancement in this field. To put it another way, take the case of the cost of drugs, or the cost of hospitalization, or the cost of the doctor's fee. One of the interesting things, and I am now talking about economics, about rapid technological advancement in any field, and there has been rapid technological advancement in this field, is that in its wake we find obsolete skills and obsolete equipment. In order to have brought about this advancement, we have to have had increased sums of money in research and development. We have had to have increased sums go into education.

Now, and I am talking about the wake again, we have the cost of retraining people to handle the new technological equipment that has come through these advancements, and each one of those items that I have listed means added cost. Where does payment for that added cost come from? How are the costs borne? They have to be borne, of course, in the price of the service or of the item that is involved.

This is not the only field in which we are experiencing this situation and rapid technological advancement. It occurs everywhere. Yet, throughout the country we have heard the cry that there is something sinister about the increased cost of medical health. People say somebody is gouging the public. It is still possible today, as I have often remarked, to buy a bottle of Lydia Pinkham's Compound. What does it sell for? A dollar or dollar and a half a bottle, instead of paying $10 for a mycin drug. So the choice is still there, but the question is, what is the quality? How much help does one get from the two products? Yet our cost of living index does not reflect all of this increase in quality. Or we get into the economics of a hospital stay. Where is it measured, or how can it be measured? Take the fact that 20 years ago a person goes into the hospital and comes out in a coffin. Maybe his stay has been two or three days. Today, the odds are that when a person goes in, he may stay a little longer, but he comes out on his own hind legs. Where is that measured in the cost of living index? Indeed, it is not. So, one thing we have learned in the field of economics is that our cost of living index does not measure quality, advance in quality. That is one of the peculiar things that exists in this area of increased medical costs. To expose some of these problems without analyzing what is behind them is surely foolhardy.

Yet, that is exactly the process that seems to be going on in Washington, D. C., in approaching this problem of health of the aged. The one thing that I do think is important is that we approach the matter affirmatively, and I am satisfied the doctors do; although their public relations may not be so good on this subject, they certainly do approach the problem affirmatively. But it is important to get the message out to the people that this matter is being approached affirmatively, that it is not being ignored, that it is not being swept under the rug as some of the opponents would say, that the problems are what we describe them to be, and then go about seeking the solution.

The Forand Bill

I want to direct my attention to some of the features of the Forand Bill, just to illustrate how demagogic the appeal for the particular bill has been and how much the facts involved in the issue have been ignored. Most people, when you talk to them, think that the Forand Bill has something to do with the indigent old people, the people who have no way to pay not just health costs but for food and rent and shelter and clothing, people who are just plain poor.

The Forand Bill has nothing to do with those people at all. Public assistance takes care of those people, or Community Chest agencies take care of them. I know what the great medical profession does in taking care and helping take care of those people. This statement was made and uncontested in the hearings on the Forand Bill last July, that there is no indigent person who does not receive or who could not receive adequate medical health care in the United States. It came up again just day before yesterday when Mr. Flemming was before our Committee, further discussing what we might be doing in this area. I took exception to some of the statements that he made and was making in this area of indigency. "You are using generalities," I said, "and I would like to find out about any specific case." "Well," he said, "You cannot prove that the other is true." "The fact," I replied, "that the statement is made that there is no indigent person who does not receive adequate medical or health care, or could receive it, is a challenge for anyone, any section of this country to call to the Congress' attention or to call to the public's attention through news items or however, that such is the case. As long as the challenge remains unmet, I think that we can, in good faith and honesty, make that statement about America."

What is our problem, though? Our problem is not the indigent, but our problem is the older person who does have some savings, perhaps, does have some income, but finds this added 10 years of life and the medical costs that go with that, because they are higher during that period than any other time, difficult to meet and certainly in the event of catastrophic illness would find it more difficult. There is the area in which we have not solved this problem. And, I might say, that we always want to try to do something to solve the problem of the indigent, but that is not a health problem alone, as I pointed out. Indeed, it is not just an economic problem. When a person is an indigent, I dare say that the spiritual indigency is just as important to him. The lack of love and affection, the lack of being wanted, the lack of being a part of things is just as important in a way as some of these other wants. So, we always want to try to attack the problem of indigency. But, I have made the point year after year, as best I could, before the House and Committee that we do not solve the problem of indigency by proliferating into a want of homes, public housing; a want for medical health, the Forand Bill; the want of food, some of our surplus food disposal programs, breaking it down into a variety of needs. Indigency should be treated on its own bottom.

Insurance

So, back to this problem of what do we do about these people who are not indigent, but who are having a difficult time of meeting their medical costs. That is where a companion profession comes into the picture, the insurance field. It is a question of whether or not the private insurance industry can meet this problem through proper premiums and through proper benefits. I think that the record shows quite clearly, and we tried to bring it out during the hearings, and I think the developments since those hearings in July show a tremendous movement forward in this field of providing adequate health insurance for our older citizens, so much so that we have moved from 1952 when 22 per cent of the older people were covered by some form of insurance, to where at the end of this year it is going to be over 60 per cent; and projecting it out into 1965, it looks like over 80 per cent. The question always comes up: Well, maybe they are covered, but is the coverage adequate? That is a fair area for debate, and there is where the public debate should be. There is where the issue should be presented to the people as to whether or not this need is being met in this area and whether or not it is necessary to have the federal government come in with tax money to do a job that possibly could be done in the private sector. I am not going to go into the arguments as to why, in my judgment, we are moving ahead rapidly to solve these problems and why in my judgment the federal government's move into it, far from helping, would destroy what progress has been made and certainly would stop what progress we could anticipate in the very immediate future. There is a record available on that subject, and I think all should look at it.

The Role of COPE

I want to go to another area, which is most important, inasmuch as practically the entire stimulus behind this movement for the Forand Bill has come from Mr. Walter Reuther and his COPE organization. This is part of a speech I made on the floor of the House a week ago Thursday and, thank goodness, it is being reprinted throughout the country. "The COPE is merely a strong right arm—the strong right arm of an

organization called the Americans for Democratic Action."

Incidentally, the ADA is composed of some very fine people—do not misunderstand that, as much as I disagree with them on some fundamental issues—composed of some of our distinguished professors of the universities, composed of some of our leading newspaper people; indeed, certain U. S. Senators and members of the Congress belong to this organization. Walter Reuther is a member of the Executive Board of the Americans for Democratic Action. Walter Reuther, in my judgment, is essentially a politician and only incidentally a labor leader. If you analyze what COPE has been operating on, you will find that it covers the waterfront. It is not just interested in problems of labor management, by any manner or means. In my judgment this is the group that has taken over the mantle of the Fabian Socialists that existed in Great Britain in the latter part of the nineteenth century and the beginning of the twentieth century. This is something that I have said on the floor of the House and this is something on which I have had much debate. But the important thing is this, whether or not they are that, they do have a conception of how they would like to see our American society set up.

When they take an issue like the Forand Bill, surely the COPE will be the strong right arm, but as soon as the Reuther propaganda machine gets going through that sector, you begin to see in the newspapers certain columnists, who do not say that they are members of ADA (but, they are), start picking up this theme song. I have watched it for years. There is where this propaganda begins to build up throughout the country, and the people are taken unaware because they do not realize that this is all part of an organization—that these men are not speaking independently as professors of our universities, or independently as newspaper men, or independently through their cartoons, and so on. They are speaking as a result of what they have decided and planned to do. That is the movement behind the propaganda of the Forand Bill. So this becomes important.

One of the areas where I think we can do the greatest good for the problems of our older citizens and really make more meaningful this 10 years additional life that you doctors and others in the health profession have granted to our society, is in the work clause, the $1,200 limitation on the amount of money a person can earn and still remain on social security, because that work clause is the very thing that forces older people out of the labor market. Now here is the interesting thing; who has opposed the liberalization of the work clause over a period of years? Yes, they have come into my office quietly and they have not done it openly. There is no propaganda on this particular one, but it has been Mr. Reuther and this crowd. They are out in the open now because we forced them out in the open in interrogation in our Committee. They are opposed to any liberalization of the work clause. They do not want these older people in the labor market. Now the significance as far as the older person is concerned is not just a matter of his own economics, the fact that he would like to work longer in order to have a better livelihood; but it is also —and I think the doctors would tell me this better because I am really quoting what some have told me, particularly those who are in the rehabilitation area or those who are in the field of geriatrics—the psychological attitude of an older person to feel that he is of some use and that he is doing something in his society that is meaningful. From society's standpoint I might say that because of the fact that these men and women have been granted this extra 10 years of life, the fact that now men and women at 65 in many, many instances are much more capable of remaining in the work force than people at 45 maybe 30 years ago would have been, the gain that society could have from their talents and their experience and their ability makes this a desirable social goal.

What is Reuther's objection to increase of the work clause liberalizing the $1,200 you can earn? He says it will cost money. I am glad that I got that response, because that is the first time I have ever heard Mr. Reuther worry about whether it cost money. Incidentally, he is right, it will cost money. That is one of the real problems involved. But I have said to my Committee colleagues, let us look at it this way, here is what it will cost, here is the social gain from it; let us match it and see whether it is worth it. In my judgment it is—indeed it is. That is the way I would like to see this program liberalized. That is one way I would like to see us move ahead in this area of trying to solve the problem of the aged.

Cost Versus Availability of Facilities and Services

Let me say something else. There has been other progress made. There are two problems in

the economics. One, of course, is the ability of the older person to pay for the facilities and the services. The other economic problem is: Are there the facilities and the services available? Because if the facilities and the services are not there, it does not matter too much how much money you have because you just do not get them. I thought one of the great bits of testimony by the representatives of the American Medical Association before the Committee in July was pointing out this aspect: I had never thought of it in this way before, but, they said, you know this matter of adequate health treatment and facilities is really not one of chronology, of whether you are young, middle-aged, or old; if it is anything, it is geographical. In an area like my own community, St. Louis, there is not a person who does not get adequate personal care because we have the facilities. But in a place which we might call a depressed area, economically, probably most of the community, young and old, might have inadequate care. So that is the point of the facilities.

Nursing Home Loans

Here is something that all doctors should know more about; your American Medical Association got affirmatively behind a bill that I proposed for three years, to provide FHA type loans to the private nursing homes. I felt that the lack of healthy, safe, economically designed nursing homes was one of the greatest needs of our older citizens. I felt that, in some ways, we were actually crowding the hospitals because people perhaps did not need full hospitalization but they had no choice. There were not private nursing homes available. The cost of a private nursing home is $1 compared to $10 for hospital treatment.

Why would the banks not lend money to build safe, adequate private nursing homes? Because private nursing homes are something new, single purpose type buildings; those of you who have dealt with bankers know that. I pleaded with them first and I could not see any progress there. Then I went to the route of a guarantee FHA type loan, and, I am happy to say, the American Medical Association affirmatively backed it. That is now law. That became law last August. Because of the dragging feet—and I am going to try to find out who was doing this—in the Department of Health, Education, and Welfare we did not get regulations available to the public until February 25 of this year. I checked just before I left Washington and there are already 700 applications for this kind of guaranteed loan. Now there is another way in which we move ahead in this area.

Visiting Nurse Approach

Let me mention another suggestion I made to the Secretary of Health, Education, and Welfare —and I have been suggesting it for a long time— hospitalization, private nursing homes, and then there is another step down the ladder that is less costly than a private nursing home. It is one where the old citizen can stay in his own home, and I might say that the Biblical injunction, "Honor thy father and thy mother," has some meaning in our society today. The development of the visiting nurse approach, where the older persons do not have to go to a private nursing home, where the members of the family can be taught with a little help, a little guidance, how they can care for the person at home—that means something, and there has been very little discussion of it on the part of the people who have been urging that we move the federal government into this area.

I just mentioned a few of the areas where real progress has been and can be made if we can get the demagogues quieted down. Keep this matter from being thrown into political partisanism. I am convinced that we will never, never solve these problems if we resort to the emotionalism, the demagoguery that I have seen used in the development and promotion of the Forand Bill and that type of legislation. On the other hand, if we will take these problems out in the open and recognize that all of our citizens and, above all, the medical profession and the professions in the health field, are deeply interested in trying to find the proper solution to these problems, then I think we will continue to make this progress.

Taking Stock

Now, how does it stand? We have had a victory beyond anyone's expectations, certainly beyond my own, in the Ways and Means Committee when everyone was predicting that my colleagues would not hold the line; yet, we voted 17 to 8—17 to 8, to reject this Forand Bill and its approach. I am convinced that it came because of arguments of this kind—the marshalling of this kind of facts. But there has been a silken curtain thrown over this. My speech on the floor of the House was not reported by any of the news-

papers in this country nor on television or on radio; the words that I spoke here today, which I expressed during the hearing, were not reported. The words of those of us who are trying, I think, to talk sense about this thing go unreported. So, while this battle is won, the war is not over. There are many battles ahead of us.

Now comes the question: will the petition to discharge our Committee prevail? Mr. Reuther has decided that his group will try to make a campaign issue in 1960 out of the Forand Bill and will abandon the Landrum-Griffin Labor Reform Bill, apparently, as the campaign issue because the public has come to know what the true issues in that were. And they are apparently going to do this. So, there is being stimulated, further, more of this propaganda from the COPE and that group. Their attempts are going to be now to infiltrate the organizations of the older people; up to date they have not moved very far in that. That is where the doctors can help. Because you know what groups of older people are organized, just watch out for the poison and get the true message across. If we can win this battle in the hearts of our people—that is where it is being fought now—I can assure you that the Congressmen who are not on the Ways and Means Committee, who have not had the opportunity of knowing the facts in this case, are not going to sign the discharge petition.

Incidentally, some of those candidates for President in the Senate who are talking about what they are going to do in this area are going to be calmed down considerably because their only interest, apparently, is votes. If you can demonstrate that there is more than one group of people in our society that is politically active, I can assure you that their ardor for an ill-conceived piece of legislation like the Forand Bill will disappear rapidly.

Nevertheless, the war is not won. Certainly, the basic war is not a political thing, the basic war to move ahead and make more meaningful the extra 10 years that you gentlemen and your colleagues have granted to the people of our society. That is what we want to achieve. I think we will do that.

In conclusion, I shall read again the passage by Thucydides: "An island of relative affluence and political freedom in a sea of slaves and savages tends to succumb to the poisons in the sullied air even if it escapes the swords and arrows of the barbarians." I am satisfied that eternal vigilance, a real participation of our people and of our society in their government, not only will preserve this island that we have here, but also will extend it on beyond the seas throughout the world, so that we shall no longer need to fear this wise observation of Thucydides made back in 400 B.C.



Automotive Crash Injury Research

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In such a symposium as the one planned today I believe that the most sensible approach to outline the medical aspects of the trauma problem is to discuss the latest research efforts of our Cornell trauma team into the various aspects of automotive injury, pedestrian trauma, and care of injuries in general.

Automotive Injury

First, in the field of the automotive crash injuries our approach has been one of further defining the efficacy of safety design in the newer model year automobiles. The original data have been well publicized throughout the country and have been reported in the medical and automotive publications. Door locks have decreased the incidence of ejection from the automobile and therefore have lessened the incidence of moderate through fatal grade injury. In reviewing case reports of 20,000 exposed occupants in automotive injury producing accidents, we have noted a 2 to 1 higher incidence of moderate injury in those occupants ejected from the car than in those occupants remaining in the car. As one proceeds through the spectrum of the injury scale to fatal grade of injury, there is an increasing severity of injury associated with occupant ejection. It is noted that those ejected from the car have a 5 to 1 higher fatality than those who remain within the car. In comparing accidents where seat belts were in use to accidents where seat belts were not in use, we noted approximately a 60 per cent maximum improvement in the incidence of moderate to fatal grade injury. A larger series has developed since this last report and again one notes a decrease in the incidence of serious to fatal injuries, but, interestingly enough, an increase in the over-all incidence of injury.

It can be hypothesized that the use of seat belts and other safety devices in automobiles has led to lessening of the impact of trauma to the occupant; therefore, decreasing fatalities are reported, but in those occupants removed from the fatality group some degree of injury is sustained; in consequence, the bulk of occupants have fallen into a lesser grade of the spectrum of injury. For example, fatal injuries have been modified into serious injuries, and serious injuries have become moderate injuries and the moderate injuries, minor injuries. Only occasional ones have decreased from minor to no injury. Accordingly, this seems to follow an anticipated pattern rather than to negate the value of seat belts and other safety devices in automobiles.

Whiplash Injury

Recently, the problem of whiplash injury was studied. Interestingly, it was noted that only 144 persons out of 12,000 occupants exposed suffered injury in what could be strictly described as exposure to the whiplash phenomenon. The term whiplash injury in our study was believed to be a poor term to describe any clinical diagnosis or entity. In the patients subjected to this whiplash phenomenon, seldom did the term whiplash injury accompany any other serious injury, and it was believed that all too often the medicolegal implications in a rear end impact led the examining physician to employ the catch-all phrase of whiplash injury. Accordingly, it was believed from our studies that the term whiplash injury was not a diagnosis and that more exact clinical data and diagnoses should replace this term for any patient suffering injury when exposed to the whiplash phenomenon in automotive accidents. At the present time, the study of the relation of injury causation to speed, top structure, windshield structure and design, center post structure and other car components is in progress.

One point of interest is that the famous cliche today in medical as well as in civic circles is "speed kills." It is noteworthy that over 80 per cent of the accidents occur in speed limits perfectly acceptable throughout the United States. Certainly one cannot say that only speeders are those involved in accidents. One also notes that because the majority of drivers observe most speed laws, the majority of accidents occur in the

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acceptable speed range. Simple elimination of speeding, therefore, while cutting down on the more hazardous and terrifying and dramatic accidents at speeds through 80 and 100 miles per hour, will certainly not remove the greatest portion of accident injury spectrum from the highways of the United States.

Pedestrian Trauma

Another project which was established at Cornell University Medical College separate and distinct from the automotive crash injury research project is a more clinical type of study dealing with the accident configurations suffered by the pedestrian. It is well known that approximately one fourth of all vehicular deaths are pedestrian deaths while the other three fourths are deaths experienced by the occupants of the automobile. Many facets of study are available, and a rather unique research project has been set up in New York City. At the present time we are in the process of data gathering and data analysis. The study so far has been confined to pedestrian deaths. When this portion of the study has been completed, it will then be extended into nonfatal pedestrian accidents.

Essentially, the study consists of a joint research program established between the Police Department of New York City, the Medical Examiner's office of New York City and Cornell University Medical College Department of Public Health and Preventive Medicine. Police Commissioner Stephen Kennedy of the New York City Police Department, Chief Medical Examiner Milton Helpern of the Medical Examiners office and Drs. Walsh McDermott, Preston A. Wade, James R. McCarroll and myself have been involved from the Cornell University Medical College. All pedestrian deaths occurring in the Borough of Manhattan have been studied in great detail. The Accident Investigation Squad of the New York City Police Department, a small picked group of men, has been assigned to study all mechanics of the accident and all injury-producing mechanisms at the site of the accident. Photographs are taken, and the patrolmen question witnesses, question the first patrolman arriving on the scene and reconstruct the accident by diagrams. All aspects of the car as to functional capacity are described; all weather conditions and other environmental data are tabulated. The effect of alcohol upon the causation of the accident or the extent of injury, the effect of ambulance transportation, and the effect of in-hospital care will be studied in the future, but at present have been ignored because only fatalities constitute the immediate project.

All fatal pedestrian accidents have been carefully reported upon by the Accident Investigation Squad and then an autopsy performed as required by law. A member of the Cornell trauma research team is present at the autopsy; all pertinent data are then collated by the trauma research group in the Cornell Medical College facility. At the present time, because this study is in the process of coding, only gross conclusions can be drawn and these are really nothing more than impressions. One notes immediately that the usual trauma imposed upon the pedestrian is that of mass trauma; therefore, one finds it difficult to indict the sharp fender ornaments or the sharp bumper ornaments on today's cars. Rather, when the patient is injured he is "injured all over." Serious head injuries, chest injuries, abdominal injuries and pelvic injuries are the rule rather than the exception. Seldom is there one localized area of trauma causing a fatality in the injured pedestrian. It is possible, however, that more minor injuries which will be investigated as the study progresses may be produced by these projecting ornaments on today's cars. To date we have no data to confirm this.

Secondly, one notes that splenic ruptures have been infrequently encountered in the fatalities observed so far. Hepatic rupture has been much more frequent and has been a major cause of the fatality. Head injury, as might be expected, is by far the most common injury and of course one of the more serious. Interestingly enough, pelvic fracture with massive retroperitoneal hemorrhage is particularly frequent. Occasionally, severe pelvic fractures have been the cause of death due to concealed massive retroperitoneal hemorrhage and profound irreversible hemorrhagic shock.

At the termination of the collection of data concerning pedestrian fatalities, the study will be enlarged to include, by representative sampling, nonfatal cases throughout the city of New York. It is hoped then to get a good cross section of the accident spectrum as it affects the pedestrian.

Care of Injuries in General

Lastly, our interest has been focused upon the functioning, equipping and handling of patients in the emergency rooms in hospitals throughout the United States. A pilot study has been recently

carried out at the New York Hospital under the direction of Dr. P. A. Wade and Dr. Paul Scudder. This emergency room study has shown many of the deficits present even in an emergency room situated in a Medical Center. It will soon be performed in hospitals more removed from University influence and environment. This will be done to study the professional coverage and physical facilities at hospitals varying from 50 to 500 beds throughout the country. By such a representative sampling of hospitals, correlated with the environment, all data concerning type of patient received, incidence of multiple injuries and other such data, one can determine the actual physical and professional requirements of an emergency room of a given size hospital. This project endorsed by the American College of Surgeons has demonstrated the great interest in this problem expressed by medicine and is therefore being pursued as rapidly as feasible when performing a clinical and environmental study such as this. At present, physical plants of emergency rooms are being studied, and it is hoped that this study can be expanded to include the environmental data and actual functional data observed from the every day experience of different hospital emergency rooms at different professional levels. This is essentially the type of research being carried on at Cornell in trauma. While the field of trauma has to a great degree remained a neglected one in the realm of research, because of the increased incidence of this disease and because it is becoming more and more a greater cause of morbidity and mortality, it is certain that more studies of even greater depth will be instituted.

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Accident Proneness in the Automobile Accident Field

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Studies of the causes of accidents reveal that certain individuals are much more likely to be involved in accidents than is the average member of the public. We commonly dub these individuals as "accident-prone." Accident proneness, of course, extends into all of the fields in which accidents occur,[1] including the home, industry, an dsports, as well as the operation of automobiles. The area, however, in which the accident-prone individual can do the most harm is probably that of the operation of the automobile, for in this field, if he has an automobile accident, he is likely to injure not only himself, but other members of the public who become involved in the accident with him.

It therefore seems appropriate to limit this analysis of accident proneness to the automobile accident field. Within these limits it is planned, first, briefly to analyze the causes of automobile accidents, including relationship between accident rates and accident proneness of individual drivers; then to point up the various factors entering into the complex picture of accident proneness, including age, experience, defective operating habits and skills, physical defects, psychomotor characteristics, and mental characteristics and attitudes. Next, the present legal and societal approach to the problem will be discussed; and finally, some tentative suggestions for decreasing the number of accidents due to accident proneness will be offered.

Automobile accidents in the United States in 1958 resulted in 36,700 deaths and 2,825,000 injuries.[2] Florida, with its myriad tourist attractions and beckoning highways, had more than its share of such accidents. In 1958, 1,134 people were killed and 33,587 injured in Florida alone.[3] An analysis of the causes of these accidents by the Travellers Insurance Companies[4] reveals that about 40 per cent of them occur on weekends, and that speeding is involved more than one third of the time. These studies also reveal that

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drivers under 25 years of age, while making up only 14 per cent of the driving population, were involved in 27 per cent of the fatal accidents in 1958. These young drivers have consistently been involved in about twice as many accidents as their numbers warrant.[5] A more revealing and certainly more startling statistic is that based on a study by Blain[6] in 1941 in which he attributes one third of the automobile accidents to a mere 4 per cent of those driving automobiles. Another study, while agreeing that 4 per cent represents an approximation of the number of accident-prone drivers, would involve them in about 14 per cent of the accidents.[7] No matter which statistic we accept, however, it still becomes extremely important to try to determine the causes of accident proneness, and to devise means of identifying accident-prone drivers before they cause a serious accident.

Causes of Accident Proneness

Studies indicate that a number of factors play a part in accident proneness. The age and experience of the driver are perhaps the most obvious factors.[8] It has already been pointed out that young drivers have almost twice as many accidents as the average driver. This increase is undoubtedly due as much to exuberant attitudes toward driving as to lack of skill. It may not be a reflection of true accident proneness since it is normally corrected by the passage of time, but it certainly indicates that more attention needs to be devoted to this group. Likewise, drivers 65 and over are involved in a disproportionate number of accidents, although not to the same extent as drivers under 25.[9] With the older group the causes are more likely to be physical and are often due to deterioration of vision or the slowing down of physical reactions, and methods of discerning these physical defects must be devised. This need is particularly great in Florida, with its increasing number of older drivers.

Accident proneness, however, may be due to factors other than age and experience. Defective operating habits and skills often render drivers accident-prone.[10] Improper use of brakes and clutch, habitual failure to use the rear view mirror, failure to give proper signals, and cutting in and out of traffic too fast, are a few common faults which, if not corrected, may lead to multiple accidents. Proper training or retraining may go far toward elimination of these factors once they are identified.

The problem of physical defects as they relate to accidents is to be the subject of the next paper. So far as accident proneness is concerned, however, defective vision seems to be the only physical defect that plays an important part.[11]

As for psychomotor characteristics, a slow perception time in itself has been found not to be a major cause of accident proneness, and likewise poor coordination is not in itself a major factor. A person, however, who reacts quicker than he can perceive is more likely to have accidents than a person who can perceive quicker than he can react.[12] While tests have been devised to detect these individuals, it may be difficult to use them on a sufficiently broad scale to catch a substantial number of drivers whose accident proneness is due to this cause.[13]

Finally, mental characteristics and attitudes may play a part in accident proneness of some drivers. Thus, drivers with high resistance to authority sometimes take out their hostility by violent driving activity in lieu of trying to solve their problems on a rational basis. Moreover, all people have cycles of exhilaration and depression. Studies of industrial accidents indicate such accidents are more likely to happen in periods of depression.[14] One Canadian study would place mental attitudes, at least insofar as they affect social adjustment, at the top of the list of causes of accident proneness.[15]

Current Legal Attitudes Toward Accident-Prone Drivers

Before we consider possible legal steps toward correcting accident proneness or eliminating accident-prone drivers from the highways, it may be well to examine briefly the present attitude of the law toward the accident-prone driver. So far as civil liability is concerned, the accident-prone driver receives no harsher treatment than any other driver. In fact, if his accident proneness is due to youth, at least if he is a minor, in theory he may receive better treatment than the average adult driver. When a minor is involved, a court will instruct a jury that in determining whether he was negligent, that is whether in the operation of the vehicle he fell below the standard of care demanded of him by society, they, the jurors, should take into account his age and experience.[16] This introduces a subjective factor which jurors are not authorized to consider in the case of the adult who is held to the standard of care of the

theoretical reasonable man or man of average prudence.[17]

If an injured plaintiff can get his case to a jury, however, the jurors will probably take a much more realistic attitude toward the assessment of liability for an automobile accident than court instructions suggest. One indication of this is found in the fact that insurance rates against liability of young male drivers are more than double those of individuals over 25 years of age. Moreover, insurance companies definitely take into consideration the factor of accident proneness by cancelling policies of individuals with records indicating accident proneness, or charging increased premiums.[18]

Our tort law, that is the law relating to civil liability for accidents, is not keyed to accident prevention, particularly with respect to accident-prone drivers, but tort law is not the only device for social control of automobile accidents. Fear of criminal fines and penalties, licensing regulations, including suspension or revocation of licenses, and development of proper driving habits and attitudes through education and through economic pressures, as for example, increases in insurance rates, provide other possibilities for solution of the problem.

The criminal law, however, at least until recently, generally has not been any more effective in curbing the accident-prone driver than has the civil or tort law. In many localities he can have a series of minor accidents, or be cited for a series of traffic violations, and escape with nothing more than payment of a fine, or forfeiture of bail in the event an actual accident has occurred.[19] Unless an accumulation of such incidents results in the loss of the privilege of driving, the process may amount, in effect, to licensing violators of traffic laws. Motorists then begin to take calculated risks, such as running stop signs, since they know the worst thing that can result is a fine. This attitude leads to disregard for the law, and the habitual violator of traffic laws is a potential cause of accidents. Studies show a definite connection between accident proneness and chronic traffic law violations.[20]

Suggested Remedies

The simplest solution would appear to be to locate the accident-prone drivers and revoke their licenses, but two difficulties immediately arise. The first of these is the difficulty in accurately singling out accident-prone drivers. Two approaches have been suggested. The first is to use a series of tests of attention, motor skills, and information, plus a driving test, to locate potentially accident-prone drivers. As yet, however, it is doubtful that sufficiently accurate tests have been devised to catch potentially accident-prone drivers without also resulting in denial of driving privileges to a substantial group who on actual experience would not fall within this category.[21] The second method is to keep records of previous accidents and the personal histories of individual drivers, and classify them as accident-prone if they have a certain number of accidents within a definite time period. This method also has its defects. To begin with, not all accidents are reported, even in a state like Florida which requires the reporting of all accidents involving personal injuries or property damage of over $50. Accidents in which no other vehicle is involved, or where a driver promptly settles with the injured party, may never reach the record books. In addition, the laws of chance will result in a certain percentage of non-accident-prone drivers falling into the repeater class, along with their accident-prone brethren. While one study, analyzing 7,197 accidents involving 2,300 operators of public transportation vehicles in Boston, would place this figure at about 10 per cent,[22] the writers of more recent articles believe that the laws of chance account for a much higher percentage of accident repeaters among the public at large.[23]

It would be appropriate for an organization such as the Air Force or a large trucking company to exclude everyone in the repeater group from driving, and such techniques have been used by industry to cut accident rates drastically.[24] It is questionable, however, whether such drastic measures should be applied to the public at large. If the tests for locating accident-prone drivers were reasonably accurate, their use as a basis for denying license applications might be justified as a proper exercise of the police power of the state in the furtherance of public safety. The Supreme Court of Florida has declared that a driver's license is a privilege, and confers no absolute property right in the use of the public highways.[25] If reasonably accurate and workable tests can be devised, so that judges can be satisfied that they single out accident-prone drivers with reasonable certainty, the denial of license applications on the basis of such tests, or the granting of temporary licenses for a probationary

period, would probably be upheld by the courts.[26] This may now be within our reach so far as discovery and evaluation of physical shortcomings and coordination defects are concerned. Respected medical opinion seems to indicate, however, that knowledge in the psychiatric and psychologic fields, where the causes of most accident proneness are probably rooted, has not yet reached the point where it can be effectively applied in the form of specific standards for licensing private motorists.[27] Further research looking toward improvement of techniques in this area seems indicated.

In addition to the possibility of taking steps looking toward denying original applications for licenses by potentially accident-prone drivers, there is always the possibility of suspending or revoking the licenses of those who have established a record of accident proneness. A statutory basis presently exists for suspending or revoking Florida drivers' licenses following a series of convictions for violation of traffic laws,[28] but it would probably require additional legislation to authorize such suspensions or revocations on the basis of being involved in accidents alone, without previous convictions for traffic violations. Moreover, since revocation on the basis of such involvement would result in preventing a small, but by no means inconsequential, non-accident-prone group from driving, it might run so counter to the American sense of equity and fair play as to make such legislation extremely difficult to enact.

Perhaps the withdrawal of driving privileges would be more palatable if a combination of the two approaches mentioned were used. When a driver develops a history of repeated accidents, he might then be given performance tests to check his attentiveness, motor skills, emotional stability, and the like, and if these tests indicated accident proneness, the legality and desirability of suspending his license would be much less likely to be open to serious question. In one way, of course, this is like shutting the stable door after the horse is gone, but at least it would prevent other horses from going on rampage to further public detriment.

An additional corrective measure that might find greater public acceptance would be to require the re-education or retraining of individuals with records as accident repeaters. Thus the licenses of drivers involved in a given number of accidents in a given period might be suspended; then these drivers would be tested to try to pin down more exactly the causes of their accident proneness. A period of driver re-education, with particular emphasis on the problem areas of the individual drivers, followed by a driving test before the suspension was removed, might aid substantially in cutting the accident rate. Both the Michigan Bar[29] and the American Bar Association[30] have supported the re-education approach, and where employed in industry, it has led to a substantial reduction in employee accidents.[31]

If such a program were adopted, it would also be advisable to apply vigorously existing criminal sanctions against those who drive while their licenses are suspended. Youthful drivers in particular often disregard such suspensions,[32] whereas if they were certain that such violations would automatically result in serving jail sentences, compliance would be much more widespread. It goes without saying that the possibility of a driver fixing tickets or buying his way out of serious traffic violations ought to be stopped and stopped promptly. This, of course, goes to the whole automobile accident problem, and not merely to that of accident proneness.

Periodic re-examination of older drivers, particularly a requirement of physical examinations by physicians appointed by the Motor Vehicle Commissioner, would also seem desirable, particularly in Florida where there are a proportionately larger number of oldsters on the road.

Summary

In summary, approximately 4 per cent of the driving population are accident-prone. The causes of their accident proneness are complex, and detection of accident-prone drivers may be difficult. It may not be possible to isolate this group or keep it off the highways entirely, but once it is realized that this small group is involved in up to a third of our automobile accidents, corrective measures will be initiated. In this process the medical profession must devise more adequate tests for locating accident-prone drivers; the legal profession must devise more adequate laws for social control of the problem; and the law enforcement agencies must adequately implement these laws to help cut down the slaughter on the highways.

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Physical Impairments as They Relate To Automobile Accidents

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Physical impairments as they relate to automobile accidents are more serious than our statistics indicate, because many accidents happen as a result of heart attacks, blackout spells, fainting spells, epileptic seizures, et cetera, where they are not called to the investigator's attention.

According to our files in the Accident Records Section, in 1958 there were 1,129 persons killed in traffic accidents, 30 of whom we know suffered from heart attacks, blackout spells, and the like, which resulted in the accidents. Their ages ran from 30 to 81.

In 1958 we examined 558,154 persons. Of this number 11,102 failed to meet our vision requirements and were referred to an eye specialist. It was necessary to restrict 31,689 to glasses, 28 to artificial limbs and 1,390 to special car equipment so that they could operate a motor vehicle safely.

In order to pass a driver's license examination, it requires a certain amount of education or knowledge as well as skill.

Through our screening process on vision we referred thousands of persons to eye specialists because they were not able to meet our requirements.

Many persons were referred to doctors because of physical disabilities which were *visible* to the examiners. In many of these cases it was necessary for the applicant to obtain certain mechanical equipment to pass our driving test.

Our examiners are not able to determine whether a person is subject to heart attacks, fainting spells, or epileptic seizures, or is an alcoholic, but the medical authorities are in a position to know those persons who are detrimental to public safety.

In 1958 the department requested 11,358 persons to report for re-examination so that we could determine the competency of their driving ability. Some caused or contributed to the cause of accidents resulting in death, injury or property damage. Many were referred by law enforcement agencies, insurance companies and medical authorities.

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Out of this group 900 drivers failed to pass the required examination and their driving privileges were suspended, 1,144 were restricted to glasses, and 216 restricted to special car equipment.

Approximately 800 medical reports were forwarded to the Medical Advisory Committee in Leon County for its study and recommendation. The Committee's cooperation is greatly appreciated by this department. These reports included those suffering from blackout spells, epilepsy, heart attacks, diabetes and alcoholism, and general physical reports.

In view of the foregoing we believe that there should be legislation provided that all persons authorized by the State of Florida diagnosing and treating epilepsy or similar disorder shall report immediately to the local health officer in writing the full name, sex, date of birth and address of every person diagnosed as having epilepsy or similar disorder characterized by momentary or prolonged lapses of consciousness or control which is or may become chronic, provided, however, that nothing contained in this section shall be construed to authorize persons who are not required to make such reports to the local health officer to certify that any applicant for an operator's or chauffeur's license is free of epilepsy or such disorders so that the Department of Public Safety would be in a position to investigate these cases.

Accidents, A Family Problem

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Over the years the medical profession has set an enviable record, practically eliminating suffering and death from many diseases that were once claiming the lives of thousands of people. The occurrence of such diseases as typhoid fever, malaria, smallpox and many others is relatively infrequent today. Public health, as a part of the broad field of medicine, played a large role in attaining this goal. As a public health worker myself, I have had the privilege during the past 12 years of working with all areas of the medical profession in attacking the problems in public health.

As mortality and morbidity have been reduced for many of the cripplers and killers of the past, accidents have come into the forefront. During this time the medical profession has begun to recognize the relation of accidental injury to the health of the people.

The World Health Organization states that "health is a state of complete physical, mental and social well being, and not merely the absence of disease and infirmity." Certainly the impact of accidental injury, both fatal and nonfatal, upon the people affects their physical state, as well as their mental and social well being. There is no doubt that the present day medical and paramedical person has a responsibility in this field. All disciplines must join hands in attacking accidents, but first they must recognize the problem involved and become aware of activities that could lead to its control.

The major portion of the time on this afternoon's symposium has been devoted to the area of motor vehicle accidents. I should like to discuss accidents as a family problem with particular emphasis in the area of home accidents and the approaches to prevention from the family point of view.

There are approximately 95,000 deaths each year due to accidents of all types. This constitutes the fourth leading cause of death in the continental United States for all ages and the leading cause of death in the most productive years of life, one to 35. Approximately 45 per cent of these deaths are attributable to motor vehicle accidents. Home accidents account for approximately 30 per cent,

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while all other accidents occur in approximately 25 per cent of the cases.

Although the fatal injury rate due to accidents is alarmingly high, the number of nonfatal injuries due to accidents of all types must not be overlooked. It has been extremely difficult to measure accurately the nonfatal injuries due to accidents, but in recent years morbidity studies have brought to the forefront more accurately this aspect of the accident problem. The most recent evidence of the extreme magnitude of the nonfatal injury problem was brought forth by the National Health Survey program, which indicates that an estimated 50,000,000 persons receive injuries involving restricted activity or medical attention each year in the United States. Morbidity studies that we have conducted in Georgia indicate that this estimate more clearly reflects the actual extent of the problem.

While the majority of fatalities from accidents are due to motor vehicle accidents, the picture is reversed in the nonfatal injury category. Forty per cent of the nonfatal accidental injuries reported through the National Health Survey program were due to home accidents, while 10 per cent were due to motor vehicle accidents. This figure, coupled with an estimated 30 per cent of the fatal accidents due to home accidents, clearly points up that the one place we consider the safest place generally proves to be highly unsafe.

The leading cause of home accidents is falls, accounting for more than 10,000 deaths yearly. This is closely followed by deaths due to fire and explosions in the home. Suffocation, poisonings and firearm deaths account for 1,000 or more home accidents every year.

Age is a most important key in the prevention of accidents. Many causes of accidents are predominantly attributed to certain specific age groups. For example, in falls due to home accidents, we have found that 78 per cent of all the deaths due to this cause occur in the age group 65 years old and older. Burn deaths occur in the younger and older age groups. Suffocation in the home occurs principally in infants. Poisonings are particularly high in younger children and so are of great interest to the pediatrician and the general practitioner. Home accidents thus become generally a problem for the younger age group and the older age group, while motor vehicle accidents are predominantly heavy in the adult age group.

Accidents as a whole are primarily a family problem. They cut across the entire family from the youngest child to grandmother and grandfather. Since they are a family problem, the practicing physician, the public health worker, and others who have contact and work with the families of this nation should concern themselves with the solution to this problem.

Factors in Accident Occurrence

The dictionary definition of the word accident is a poor one for describing what happens in an accident situation. It tends to leave the impression that accidents are inevitable and that there is not much that can be done to prevent them. It further gives the impression that an accident is a sudden occurrence and an unforeseen happening. Neither is true because accidents are often slow in onset and usually are foreseeable, even predictable. If a person is able to recognize and be aware of the factors leading to an accidental occurrence, he stands an excellent chance of preventing it.

There are several factors involved in an accidental occurrence. This view leads to a concept differing from that previously accepted in that a home accident should be viewed in terms of a sequence of events leading up to a measurable or recognizable result, such as injury, death, or property damage.

With this concept it is easy to recognize that there are many factors behind an accidental occurrence and that accidents are not something that "just happen." If the physician is aware of the basic factors lying behind the accidental occurrence, he will be able to evaluate and do a more effective job in preventing this occurrence. Just as in disease, there are causes for all accidents; therefore, they can be prevented.

There are two major aspects of accidental occurrences found in all of the factors of the accident sequence. These are environmental aspects and human aspects. Accidental occurrences always involve one or both of these aspects, usually both.

The environmental aspects include the many adverse conditions introduced through the environment of man, such as the home itself. Poor construction, slippery floors, loose stair treads, poor storage of poisons and medications—all are environmental aspects where control measures can be practiced. The human factor is the least tangible and the most difficult to recognize and

to measure. It involves human behavior and the change of such behavior to prevent accidents. It also involves such things as crippling conditions, haste, fatigue, and the most intangible of all, poor judgment.

These aspects and factors of accident occurrence are all directly related to the family and the home in which the family lives. Each and every person must accept accident prevention as a way of life, just as he has accepted the brushing of the teeth and the washing of the hands as a personal hygiene way of life. The practicing physician can contribute greatly to the solution of this most complex problem of accidents.

What the Physician Can Do

Much effort has been made in the field of accident prevention in years past by many organizations and agencies. For example, police agencies have attacked the traffic safety problem with much vigor. Industrial safety engineers have an enviable record in the reduction of occupational accidents through safety education and changes in the working environment. A few years ago it was recognized by such agencies as the National Safety Council, the United States Public Health Service and the W. K. Kellogg Foundation that little coordinated effort was being carried out in the area of home accident prevention. At this time the health departments of the states were urged to enter the field of home accident prevention mainly because of their close contact with the families. Some of their programs have since been expanded into the entire area of accident prevention.

During the last five years it has been amply illustrated that the medical and public health professions can apply their skills and knowledge in many ways in the field of accident prevention. Public health departments, which have been placing more and more emphasis on the problem of accidents, are uncovering knowledge as to how they can apply their skills and technics to the preventive aspects of this problem. In the past I fear that those working in the area of safety placed a great deal of emphasis on the personal or individual approach to accident prevention. What is needed is a family approach in an effort to establish good, safe practices as a normal, acceptable way of life. In this respect it is imperative to get parents to instill in their children an awareness of the situations with which they may be faced during life that could result in injury. Until the individual, through family living, learns to recognize situations that could lead to injury or death, I fear that growing reductions in the accident prevention field will not be realized. The individual must recognize these situations through normal instinct and reaction and can only do so by good, safe practice within the family structure of the home.

The physician who treats the various ills of the individual members of the family is in an enviable position to prevent accidents. He has a unique potential in reducing the accident problem. In view of this, the physician must assume responsibility in this field.

It has been illustrated that person-to-person contact in safety education is the most effective method of getting across the accident prevention message. The physician, in his relationship to the patient, is in a position to teach practical accident prevention at the most effective time. The mother who brings the child to the pediatrician for the treatment of a burn injury is at this time more in a frame of mind to receive good, practical safety teaching than she will ever be at any other time.

It has been experienced in the past that the occurrence of an accident to an individual within a family can be a stepping stone to a teaching experience to prevent recurrence of this and other accidents withint the same family. Morbidity studies conducted by the Georgia Department of Public Health in the past few years have indicated many cases in which there have been several accidents within the family apparently related to the environment in which the family lives or the emotional atmosphere of the family life. It stands to reason that in the physician-patient relationship, particularly when the patient has suffered an accidental injury, the person-to-person contact of safety teaching can go far toward reducing the number of accidents occurring within the family.

One of the greatest problems in the accident prevention field has been the lack of morbidity information on accidental injuries. The physician can render a most important service to the field of accident prevention by cooperating with agencies responsible for accident prevention in furnishing data on injury cases treated by him. In order that practical measures of prevention may be developed by safety agencies, all of the basic factors in the sequence of events leading up to an accidental occurrence are needed in order to

formulate specific preventive measures. The physician can render an important service by cooperating with his health department or other agencies in his community in providing information on accidental injuries that come to his attention.

The physician is a highly respected person in the community, and his opinion is highly regarded by all with whom he comes in contact. He can render an important service to the community by lending his support to agencies in the community charged with the development of accident prevention programs. His influence in getting good and practical accident prevention legislation passed for the protection of the community can be invaluable. He has a fund of scientific knowledge that can be most effectively used in developing workable laws that can reduce accidents and be practically enforced without hardship on the community.

No one agency alone can ever hope to do the job in this field that lies ahead. It must be a cooperative effort of all responsible agencies and individuals in the community pulling together in a workable program. Such agencies as the police department, fire department, health department, building inspection department, local safety council, and others may be charged by law or otherwise with responsibility in this field. The practicing physician can lend a great deal toward making the programs of these agencies more meaningful, more workable, and in the long run, successful. His help is badly needed.

Special Page to Contain Items Of Current Interest

The Editorial Board of The Journal has decided to establish a special page in each issue devoted to items of current interest and last minute news releases which should be brought to the attention of the members of the Florida Medical Association. It is probable that the material contained on this page will be devoted most frequently to legislative matters, medicolegal and insurance affairs, current medical news items of general interest, and similar material. Such a page will not necessarily appear with each issue, but only as the need for it should arise.

It is suggested that any member of the Association wishing to submit material for this page contact a member of the Editorial Board in his vicinity. This will then be forwarded to the undersigned or to Tom Jarvis, Managing Editor. Deadline for this last minute information should be the fifteenth of each month prior to publication of The Journal.

It is suggested that the folllowing physicians be contacted by any member wishing to utilize this special page: Dr. Edward R. Annis, Miami, Chairman of the Committee on State Legislation; Dr. H. Phillip Hampton, Chairman of the Committee on National Legislation; Dr. Kenneth A. Morris or Tom Jarvis, Jacksonville; Dr. John M. Packard, Pensacola; Dr. W. Dean Steward, Orlando. Suggestions and comments concerning the proposed new page and its contents will be welcomed by the Editorial Board.

Hawley H. Seiler, M.D.

VOLUME XLVII
NUMBER 1

Hereditary Chronic Nephritis

JOHN B. NEAL, M.D.
JACKSONVILLE

There have been various reports in the medical literature concerning a hereditary type of nephritis designated as hereditary interstitial pyelonephritis,[1] familial nephritis,[2] hereditary nephritis,[3] hereditary familial congenital haemorrhagic nephritis,[4] congenital hereditary hematuria,[5] hereditary hematuria,[6] and hereditary chronic nephritis.[7]

This is a presentation of three cases of chronic nephritis in the same family which seem to fit this hereditary type of nephritis. These cases are those of a mother and two of her sons.

Perkoff and his associates[7] studied a large family of 168 members, 49 of whom had definitely abnormal urines. Of the 49 affected, eight were males and 41 were females. The clinical findings were usually pyuria, hematuria, proteinuria and cylindruria. The disease seemed to progress faster and was more severe in male members. Intravenous pyelograms were normal in affected members of the family. It was not unusual for bacteria to be cultured from the urine, and the urinary findings seemed to clear somewhat on antibiotics. Of those who died in uremia, the autopsies showed varying degrees of interstitial fibrosis and lymphocytic infiltrations and hyalinized glomeruli. Some kidney specimens contained interstitial foam cells. Clinically, some of the members of the family with urinary findings also had high tone deafness and some without urinary findings had high tone deafness. This relation was not clear. These authors explained the mechanism of inheritance on a sex-linked dominant basis. In their cases the patients apparently did not go through clinical stages of acute nephritis or show signs of nephrosis. In most cases the disease was discovered on routine urinalysis.

Sturtz and Burke[6] of the Mayo Clinic studied several families with a syndrome of hereditary hematuria, nephrosis, and deafness usually transmitted as an incompletely sex-linked dominant trait. They found in their cases that progressive fatal renal disease was inevitable in male members, but in the women members of the family the syndrome was relatively benign except during pregnancy, when hypertension, edema and other signs of toxemia appeared.

Report of Cases

In the three cases presented here, the mother, age 39 years, has had a chronic mild (1 plus to 2 plus) albuminuria and pyuria in catheterized specimens for many years which seemed to become worse during pregnancies. She has had several normal intravenous pyelograms, and the nonprotein nitrogen has always been in the normal range.

Her oldest son, age 16 years, has had chronic nephritis since the age of six when he was found to have red blood cells, casts and albumin in the urine on a routine urinalysis. He has continued to run 2 plus to 4 plus albuminuria with red blood cells, white blood cells and casts in the urine. Over the past eight years, he has been studied in four large medical centers with negative findings except for the abnormal urine and occasional urine culture of a hemolytic staphylococcus albus from the urine. The negative findings included negative urine cultures for tuberculosis and normal amino acid studies of the urine. The urinary findings clear somewhat on antibiotics, but never completely. Several intravenous pyelograms were normal. On a routine preschool examination on Sept. 29, 1958, the urine showed specific gravity 1.015, albumin 4 plus, sugar negative, red blood cells 21 and white blood cells 10 per high power field, hyaline casts 38, hyalogranular casts 16, and granular casts 3 per 40 low power fields. The physical examination including retinal study was entirely normal. The blood pressure was 110/70 mm. Hg. There was no edema or history

Urinalysis: Specific gravity 1.013, albumin 4 plus, glucose negative, and red blood cells 8 to 12 per high power field.

Reticulocytes	0.4%	Red blood cells	2.94 mil/cmm
Nonprotein nitrogen	128 mg%	Hemoglobin	7.8 Gm/100 cc
Total protein	5.9 Gm%	Hematocrit	24
Albumin	4.5 Gm%	White blood cells	6,050
Globulin	1.4 Gm%	stab forms	3
A/G ratio	3.2	segmented forms	47
Sodium	151.1 mEq/1	eosinophils	3
Potassium	4.9 mEq/1	basophils	1
Chloride	106 mEq/1	lymphocytes	46
Carbon dioxide	18.0 mEq/1	Sedimentation rate	35 mm/hr

of edema. The boy looked pale and admitted easy fatigue. Laboratory studies during hospitalization at Baptist Memorial Hospital on Oct. 28, 1958, showed the following values:

Urine culture yielded a hemolytic staphylococcus albus resistant to tetracycline and sensitive to Chloromycetin, Furadantin, erythromycin and penicillin.

Urine concentration test:

Time	Amount in Cubic centimeters	Specific Gravity
10:00 a.m.	390	1.009
11:00 a.m.	275	1.011
12:00 p.m.	185	1.011

An electrocardiogram and a roentgenogram of the chest were normal.

As the laboratory studies show, this boy is now in a moderately advanced state of uremia.

The next son, age 12 years, by a second marriage (half-brother of the boy age 16) was found to have abnormal urinary findings at the age of six years on a routine check-up. He has also been extensively studied in several large medical centers in the past six years with negative results except for abnormal urine and occasional culture of hemolytic staphylococcus albus. He has also had several normal intravenous pyelograms. On Sept. 29, 1958 on a routine preschool examination his urine showed specific gravity 1.017, albumin 2 plus, sugar negative, red blood cells over 300 and white blood cells 12 per high power field, and hyaline casts 2 per 40 low power fields. On physical examination, except for being slightly overweight, he was entirely normal. The blood pressure was 108/70 mm. Hg. The retinal examination was normal. There was no edema or history of edema. The nonprotein nitrogen and other blood studies have always been normal. Laboratory studies at Baptist Memorial Hospital on Feb. 7, 1959, showed urine specific gravity 1.014, albumin 3 plus, sugar negative, white blood cells 1 to 2 per high power field, red blood cells loaded, nonprotein nitrogen 27.5 mg. and urea nitrogen 16.0 mg. per hundred cubic centimeters. Urine culture showed hemolytic staphylococcus albus resistant to tetracycline and Chloromycetin and sensitive to Furadantin, erythromycin and penicillin. The urinary findings clear somewhat on antibiotics, but the abnormal findings always recur.

The youngest son, age 10 years, has shown no abnormal urinary findings. There are no daughters. Adequate history on the grandparents is not available. The fathers have shown no abnormal urinary findings.

Discussion

Perkoff and his associates[7] characterized this disease as hereditary chronic nephritis of unspecified type with a high incidence of superimposed renal infection and normal intravenous pyelograms.

In none of the three cases presented here have the patients ever shown any signs of acute nephritis or the nephrotic syndrome. Cholesterol levels have remained in the normal range in both boys (under 250 mg. per hundred cubic centimeters). There has also been no indication of hearing impairment although audiograms have not been made.

The question may arise as to whether or not this is a hereditary tendency to acute nephritis. None of the reported cases have been characterized by acute nephritis. The disease is discovered on routine urinalysis and progresses slowly. In acute nephritis, most patients recover, but in hereditary nephritis there have been no recoveries reported. One wonders how many cases of chronic glomerulonephritis fall into this hereditary type and are not recognized. For instance, in a small family, if only one boy shows the disease, the mild relatively benign condition in the mother or a sister may be overlooked, and the hereditary aspect would not be apparent. When a child is found to have chronic nephritis, other children in the family and the parents should be carefully studied for chronic nephritis. The hereditary defect in this disease is unknown at this time. I have seen no reports of cortisone being used in this condition, probably because of the superimposed infections. Cortisone has not been tried in the three cases presented here.

In view of the infectious element in this disease, the two boys and their mother were sent to Dr. John Ross at the Jacksonville Blood Bank for electrophoretic studies to rule out agammaglobulinemia. As shown in figures 1, 2 and 3, the paper electrophoretic patterns are almost identical. The percentage of albumin is lower than the normal range, and the percentage of beta and gamma globulins is greater than the normal range. The exact significance of these findings is not clear. Gross[8] in a recent review of causes of hypergammaglobulinemia stated: "Acute infections first cause a rise in alpha globulins and a fall in serum albumin. It is only when the infection is sufficiently prolonged or produces a local lesion, such as an abscess or endocarditis focus from which antigenic material and breakdown

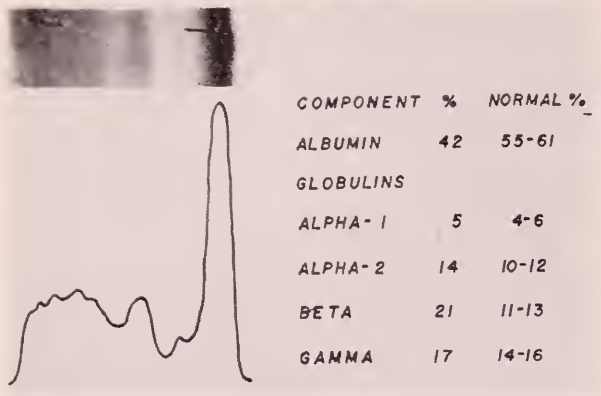


Figure 1.
Boy—Age 16

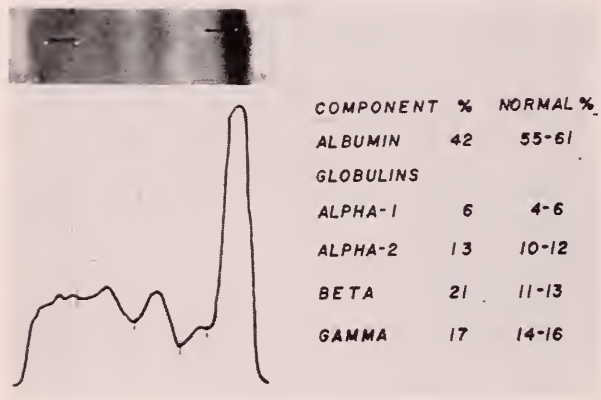


Figure 2.
Boy—Age 12

products are absorbed, that a really significant rise in gamma-globulin levels occurs. Chronic granulomatous infections, such as tuberculosis, leprosy, lymphogranuloma venereum, kala-azar and visceral larva migrans, are most often associated with marked hypergammaglobulinemia. The rise may reflect the formation of specific antibody or nonspecific 'inert' gamma globulin or both."

Some of the other conditions which are listed as causing hypergammaglobulinemia are nephritis, rheumatic fever, histoplasmosis, liver diseases, severe malnutrition, neoplasms, dysproteinemias, connective tissue diseases ("collagen" diseases), granulomas, and some dermatologic disorders. It is possible that the increase in globulins in the

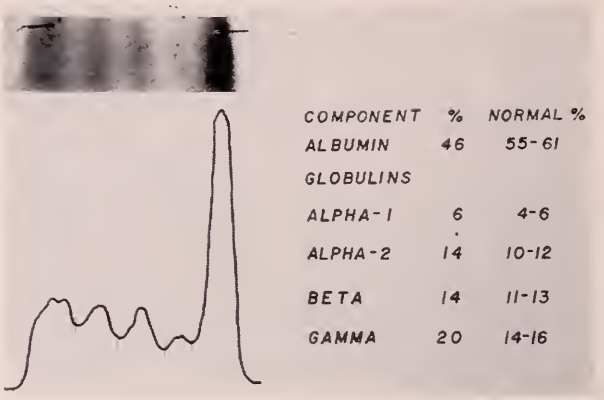


Figure 3.
Mother—Age 39

cases presented here is a nonspecific reaction which is seen in the chronic diseases listed.

Summary

Three cases of a hereditary chronic type of nephritis in a mother and two of her sons are presented. The literature is reviewed. Clinically, the disease is a chronic nephritis with some superimposed renal infection. Intravenous pyelograms give negative results. The disease is severe, progressive and fatal in males, but often mild and relatively benign in females. The inheritance is apparently on the basis of some complex sex-linked or sex-influenced trait. The hereditary defect in this disease is unknown at this time.

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ABSTRACTS

The Combined Treatment of Cervical Cancer. By Courtlandt D. Berry, M.D., South. M. J. 52:678-680 (June) 1959.

As the author states, this paper is offered as an emphasis to some melancholy facts about gross invasive cervical cancer as seen in private practice; namely, that this disease is common and lethal, and its treatment hazardous, expensive, and often unsatisfactory. A series of 50 cervical carcinomas is reported, approximately one-third each being treated by irradiation alone, radical surgery alone, and a combination of these methods. From his experience the author arrived at nine conclusions which led him to his present "combined treatment." The method now employed consists of 2,000 r irradiation, followed in four weeks by 5,000 mg.hr. radium, in turn followed in four to six weeks by radical surgery. TESPA is administered at the time of radium application and repeated at the time of operation.

Intestinal Duplication Cyst of Abdominal Origin Presenting in Thorax. By Harold C. Spear, M.D., Dewitt C. Daughtry, M.D., and John G. Chesney, M.D. J. Thoracic Surg. 37:810-814 (June) 1959.

The purpose of this article is to report a case in which an intestinal diverticulum extended through the right diaphragm to present as a large cystic mass in the right hemithorax. This anomaly is essentially an intestinal duplication which retains connection, either open or closed, with its point of origin from the small intestine but which is sequestered in the thorax by the formation of the diaphragm. It is one of the many anomalies producing serious symptoms in infancy which, if recognized and appropriately extirpated at an early age, is amenable to complete cure. In the case reported the diverticulum originated from the small intestine and traversed the right diaphragm to present in the right thorax as a large cystic mass which compressed the thoracic structures to produce symptoms of cough, respiratory difficulty and cyanosis in a three week old infant. In the three cases previously reported the thoracic diverticulum was in open communication with the small intestine, but in the present case the cystic lesion was attached to the small intestine in the region of the retroperitoneal duodenum by means of a blind stalk. Operative approach was by right thoracotomy. The cyst was found to have produced total atelectasis of the right lower lobe. Fortunately, the entire cyst, together with its subdiaphragmatic extension and a portion of the stalk, could be excised from the thoracotomy approach, thereby averting the possibility of a secondary abdominal operation.

Roentgen Change in Disease of the Appendices Epiploicae. By David Kirsh, Ph.D., M.D., and Rudolph E. Drosd, M.D. Am. J. Roentgenol. 81:640-649 (April) 1959.

Acute disease of the appendices epiploicae is relatively unknown to radiologists although familiar to most surgeons. In 1953, 102 cases were collected in the surgical literature, but these authors found no report in the American radiologic literature concerning acute afflictions of these structures. Since the diagnosis is practically always made only at the time of celiotomy for a "surgical abdomen," few patients have had preliminary roentgenographic studies with barium. The authors were able to collect seven surgically proved cases of gangrene, torsion or inflammation of an appendix epiploica, which they describe, together with the roentgen findings in four of the cases. In three cases barium enema studies revealed different findings in each case. In one case the abnormality simulated an encircling carcinoma; in the second case there was evidence of an extrinsic mass and in the third case, of spasm and edema of the mucosal folds. A scout roentgenogram in a fourth case disclosed reflex ileus.

The authors point out that the clinical diagnosis is usually elusive in patients with inflammatory conditions of the appendices epiploicae. They observe that with the assistance of adequate clinical information, the diagnosis of torsion, thrombosis, gangrene or inflammation of an appendix epiploica may be suggested in the presence of certain changes on a barium enema study or a scout roentgenogram, if not as a primary diagnosis, then at least as a diagnostic possibility.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

It's Later Than You Think

That this is an election year cannot be questioned. Simply enough, 1960 is evenly divisible by four. Equally simple are the concomitants in legislative circles of election year portents that protrude into our consciousness from the mass of run-of-the-mill type of legislation emanating from the Capital.

Apparently, the well-being of our senior citizens is not of sufficient importance in itself to warrant thorough study of the needs of those over 65, the actual numbers of those requiring assistance, the available agencies and services state by state, and the most democratic method of financing whatever plan evolves. The fact that the White House Conference on Aging will not be held until January 1961 is no deterrent to those who would "point with pride" to any bill that a major political party had sponsored and passed for the old folks, primarily to assure their vote. The years never seem to prove to any segment of the voters that "you don't get something for nothing"—that give-away programs have to be paid for.

Whether or not such momentous legislation is passed before this page is printed or before this session of the Congress goes into blessed adjournment, we physicians individually and as an organized group must continue the unending battle to direct that which we alone are trained to do—to promote the care and preserve the health of the citizens of this nation.

If selfish politicians are to attempt to tell doctors how medicine is to be practiced, beginning with the treatment of those over 65, and this would be only the beginning, then surely it would be no paradox for physicians to attempt to tell politicians what laws to pass, including some that might inure to their benefit at the polls.

Our traditional aloofness as physicians to things legislative and fiscal on the national scene has been a thing of the past for the past decade. We are apparently in this for keeps. That means that we must use all that we have—wits, funds, votes—to influence the shaping of the platforms of both parties and the nomination of both candidates and then campaign regardless of party for the one who holds the greatest promise—not makes the most promises—to stand and fight for that which we have been trained to expect—to practice our profession for the greatest good of all the people, unhampered and unencumbered by so-called third party intervention. It's later than you think!

Leo M. Wachtel

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Communication

III. Medical Care Insurance Companies

Those pesky medical insurance forms have caused each of us doctors to swear at one time or another. They have also caused our collection percentage to climb, and have been partly responsible for preventing greater inroads by the federal government into the practice of medicine. If medical care insurance is so good for doctors in general, why does it so often aggravate the individual doctor?

His complaints may be numerous: the multiplicity of forms and questions; the lack of carbon copies for his files; the implication of fee setting, whereby he is either liable to be considered a fee gouger if his fee exceeds the allowable limit, or he finds himself submitting a lower fee in keeping with the insurance schedule and then having to hire extra clerical help to complete the forms. Another complaint concerns the curious paradox that a patient, dissatisfied with the coverage received, is all too apt to blame the doctor, rather than the insurance salesman who implied that all costs would be covered, or the patient himself for failing to read and understand his policy. Then, too, the doctor may be angered by the patient who does not pay his bill after having been reimbursed by insurance, and he is perplexed by the frequent finding that because one patient may have two or more policies, the patient will make a "profit" from being hospitalized.

These and other complaints are discussed, and a most lucid description of the present status of medical care insurance is presented by C. Marshall Lee Jr., M.D., in a recent essay in the New England Journal of Medicine.[1] Dr. Lee, Assistant Medical Director of the John Hancock Mutual Life Insurance Company, has reviewed the subject of medical care insurance so completely that no editorial could justly summarize it but only urge that it be read by each physician in private practice, by the officers of all insurance companies offering medical care coverage, and by the officials of groups or unions who purchase group policies.

It is not surprising that many problems exist in such a rapidly expanding field (130,000,000 persons are now "covered" by voluntary medical care insurance plans) which is so financially im-

portant (premiums paid in 1958 exceeded four and one-half billion dollars). They can be solved only by better understanding all around. The insurance companies must understand why it is impossible to tie a price tag to each and every medical and surgical procedure, why complicated and dissimilar forms are slow in being completed, and why it is important to emphasize what is *not* covered as well as what is covered by their policy. The patient must understand the limitations of his coverage, and should again be brought to realize that it remains his personal obligation to pay the doctor's fee whether or not he has purchased insurance to help defray such expenses. Finally, the doctor must better understand the differences between types of policies—indemnity versus service, major medical versus comprehensive, et cetera—and must continually be made aware of the danger of bankrupting voluntary medical care insurance, with government-subsidized schemes an inevitable result, by agreeing to unnecessary hospitalization or by insidiously raising fees with each increase in coverage offered by insurance companies.

Only better communication between insurance companies, patients, and doctors will solve the present problems and abuses, and enable the voluntary prepayment plans to be broadened and strengthened. This improved communication is a necessity if we wish to quell the growing demand for federal intervention in the practice of medicine.

J. M. P.

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Tuberculosis: The Time Is Now

During the past half century scientific advances and improvements in community health standards as well as in the standard of living have helped push back tuberculosis. The last decade has shown a marked fall in the death rate and case rate of tuberculosis, but a time for planning has come. The United States Public Health Service and the National Tuberculosis Association asked a small group of national tuberculosis leaders to define the present gaps in our program of handling tuberculosis and to suggest what actions were needed. Eighteen conferees deliberated for three days at the Arden House, Harriman, N. Y., in November 1959. Their recommendations constituted The Arden House Report.

It is entirely feasible that human tuberculosis can be completely eradicated as a force in the United States, just as bovine tuberculosis has been eradicated. The time is auspicious, but whether society chooses to put itself to the trouble of attaining this goal remains to be seen.

Varied public health measures have already eliminated several diseases from this country—yellow fever, malaria and typhus fever by removing the vector; smallpox by immunizations. Now, by the widespread application of chemotherapeutic treatment of all known and unknown existing reservoirs of tubercle bacilli, human tuberculosis can be eradicated. The unique aspect of this recommendation lies in its emphasis on such chemotherapy primarily as a *public health tuberculosis control measure*—to sterilize all existing tubercle bacilli.

This concept connotes a new principle to many physicians, that is, widespread use of antibiotics for elimination of sources of infection. Isoniazid is the key to this concept—used continuously, without interruption, alone or in combination with other drugs over adequate periods of time, 90 per cent of patients can be rendered noninfectious and 95 per cent if surgical cases are included. Persistent acid-fast strains are causing more new infections, but only when the current irregular and disorganized haphazard methods of therapy are being applied. We are working against time to prevent the swelling of this minority of drug resistant bacilli.

It would be unrealistic to minimize the enormous effort that would be involved to get this campaign started. Many gaps must be filled. Former patients made inactive by older methods are frequently overlooked; efficient case registers

do not exist in many communities; too many patients are still being discharged against medical advice from tuberculosis hospitals; and the shift to good outpatient long term care after initial hospitalization has been inadequate. There are inadequate social services such as education for care of the patient and his family; inadequate occupational adjustment and retraining of the patient; inadequate detection programs; inadequate identification and follow-up of contacts; inadequate reporting of inactive and active cases and deaths from tuberculosis; and inadequate diagnostic facilities for physicians as well as inadequate consultation for home care. To fill in these gaps there must be enthusiastic cooperation of the medical profession both as individuals and as members of organizations, of the municipal, county, state and national health officers, and of the lay and professional members of voluntary health organzations. It is hoped that all persons even remotely interested in public health will study these recommendations and consider applying them in their own situations. The time is ripe. The "Big Push Is On."

Henry M. Yonge, M.D.
Pensacola

Venture In Medicine

At first thought it would seem helpful if I, or someone, could stand here at the Professors' Hour and tell you how to achieve the best in medicine. As Juniors and Seniors you are already launched on the way towards your goals; yet at the same time the end points you seek are probably hazy and anything but clear. This is the way it should be. If I could point out the fine achievements you should strive to attain, or the medical honors which would furnish a goal for you, I would do you a disservice. The venture in medicine lies in another direction.

In a complex society it becomes necessary to appraise individuals quickly. Medicine does not escape this need. Choices must be made for hospital staff positions, for research grants, for teaching positions, for lecturers, even for the authors of books we read. It is natural that objective measures be sought and used in making these selections.

What has the man done? What are his titles, what books has he written? List his collection of professional organizations, and name his honors. The longer this curriculum vitae, the more impressive the applicant. This approach seems to be necessary today, but this does not make it good.

This practice tends to place emphasis on reaching objectives which can be easily measured by others. It sets narrow limits on a man—gives him direction, yes—but hinders individuality. Carry this through and we would all fit a mold, we would look alike, we would aim alike. By this trend we could stifle the very spark we need the most.

You are full of questions, uncertainties, and an enthusiasm which fills your life and spills over into others. The things that need to be done, the unknowns to be answered, and the many roads of a medical life make you impatient to be about it. If this is not true, then you had better look about you, for somewhere along the way you have missed something—something essential.

The different fields of medicine have taken on some sort of prestige stratification. Research is higher than teaching or vice versa. Specialization gives luster which general practice lacks. Full time employment finds itself on a different rung than does private practice. These differences will vary with time and place and are superficial because they are not based on true worth.

Medical careers seem to divide themselves into four broad fields. These are patient care, teaching, research and administration. Opportunities exist in each of the four or in combinations. When you have chosen the road you are to take, whether by chance or by plan, you can find a full, useful and rewarding life. No one of these is higher or lower, better or worse than the others.

Hold fast to any creativeness you may have. Keep your uncertainty, your venturesomeness in

A talk before the Juniors and Seniors of the University of Miami School of Medicine at the Professors' Hour, May 26, 1960.

ideas, and retain your desire to question and to wonder. This is necessary if you are to achieve excellence in any of the medical fields.

Always remember that your life is tied in with an interest and love of man. There will always be the need to learn more and more about him and to follow man as he interacts with his environment, which is forever changing.

It is not sufficient that you focus your effort and energies into things which directly concern medicine. It is important to become aware of the truth and beauty of color, form, and sound. A knowledge of the interrelationships of the present, past and future must be gained. Ideas must be shared and there must be a search for answers to purpose—to being. A sense of responsibility must be developed towards family, community and even broader circles. It is these things along with an appreciation of little simple everyday things which enrich life and which bring understanding and humility.

In this way, as one pursues his medical career, he lives and grows and becomes much more than just what he accomplishes. Love, understanding and wisdom are born. Here is the venture in medicine, the venture of life itself.

I should like to thank the Seniors for our Monday afternoon conferences. I have enjoyed these each week and I have learned something at each conference, said something, or gained a concept that would never have entered my mind if it had not been for you. You have the enthusiasm, the questioning, the uncertainty of which we spoke earlier. Keep all this and you will find the true venture in medicine.

FRANZ H. STEWART, M.D.
CLINICAL PROFESSOR OF MEDICINE
UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

Florida Medical Association 1960 Golf Tournament

The annual Florida Medical Association Golf Tournament was held at the Selva Marina Country Club in Atlantic Beach during the Annual Meeting of the Association in Jacksonville.

The Duval County Medical Society Trophy for low net was awarded to Dr. James T. Shelden of Lakeland, and the Orlando Loving Cup for low gross to Dr. George M. Stubbs of Jacksonville. The names of the winners were announced at the buffet dinner and dance sponsored by the Woman's Auxiliary for physicians and their wives.

Other physicians awarded prizes included Drs. Joseph C. Von Thron, Cocoa Beach; Frank B. Hodnette, Pensacola; Joseph W. Taylor and Zack Russ Jr., Tampa; Nathan Weil Jr., William H. McCullagh, Harry W. Reinstine Jr., Howard C. Duckett, E. Frank McCall and William J. Knauer Jr., Jacksonville.

First Medicolegal Seminar University of Florida

The witness began to testify. His statements were a stream of confusing, Latin-sounding terms. To him—a physician and expert witness—the testimony was perfectly clear. It was an explanation of a medical problem and had to be explained in medical terms.

The lawyer heard a confusing jumble of syllables without much clear meaning, and it was not just an isolated occurrence. Most of the lawyers' civil case work consists of sifting, threading and understanding such talk. Seven out of 10 civil cases today involve medical testimony.

One crop of fresh young barristers, the graduating class of June 1960 at the University of Florida, will be able to nod intelligently at the complicated medical terms—and mean it—when they enter practice. Twenty sixth-semester law seniors are enrolled in a pilot Medicolegal Seminar at the University this semester, placing them in a group of students from about 30 other law colleges in the nation which now offer this type of training. They are particularly fortunate, however, for they are on a campus that has a medical college, also. While others have recognized the need for this type of background, they often have had to rely on a single doctor in many cases to conduct the entire medical portion of such programs.

Each week, law seniors hear a different medical expert in some new area of medicine. The course was timorously offered with some hope that enough students would enroll to justify scheduling the seminar. Only the first 20 were admitted and nearly as many more were turned away. The interest is not confined to law students. Many medical students and nursing students have requested permission from Law Professor Leonard Powers to enroll or even audit the course.

Powers coordinates the medical and legal aspects of the course for the students, relating medical information to legal practice. Dr. Richard T. Smith, College of Medicine, arranges the College of Medicine's portion of the program, lining up lecturers and assisting in scheduling among other tasks.

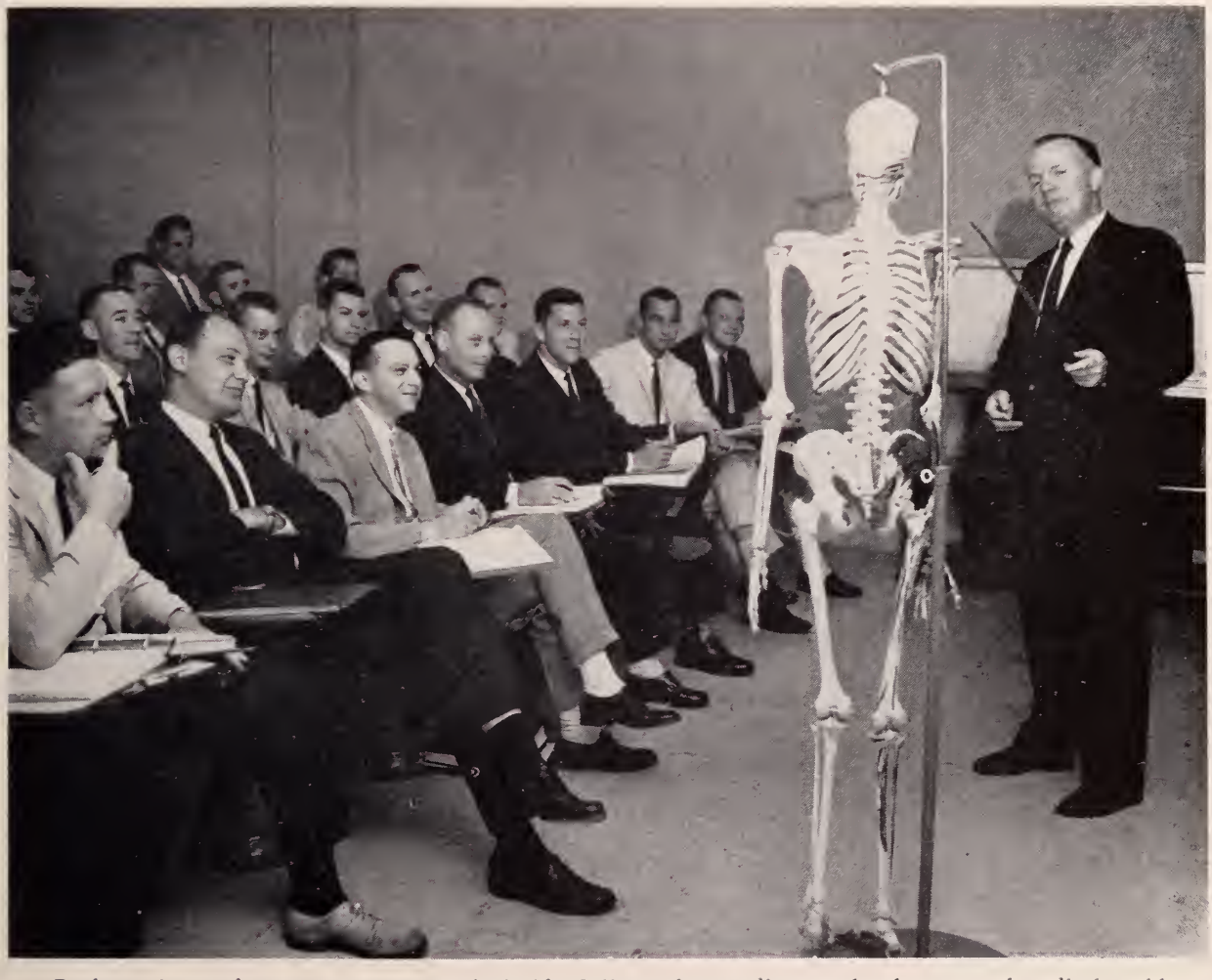
"Unfortunately, we could not accept any further enrollment this semester," Powers explained. "Perhaps the experience gained this semester will allow us to expand the program in the future. It may be that a reverse situation will develop, also, where the medical students can arrange a seminar with the law faculty. Right now, though, I cannot even guess what development the future will hold for the course."

Students enrolled in the course attend a two hour session weekly and receive two hours' credit for the seminar. There is no text for the course since it is a relatively recent development in the field, but there are two shelves of medical books in the library of the Law College. Assignments for the week's specialty are made from this collection of books, chosen after consultation with members of the medical and law faculty.

At the seminars, the students hear a different doctor each week, who speaks on his specialty for 30 to 40 minutes. Following a formal presentation which usually includes models, drawings, x-rays and other visuals, the session is thrown open to discussion and questions.

Student acceptance of the new course is attested by the fact that there has not been a single absence all semester. "Several times this semester, I have had to break up the question session more than an hour after scheduled class time," Powers said. "I believe the students would have been there yet—if the doctor had the time and I had let them continue."

Lectures and classrooms are not the only factors involved in the seminar. A list of seminar participants is supplied to the College of Medicine at the beginning of the year. Then as autop-



Professor Leonard Powers, University of Florida College of Law, discusses legal aspects of medical problems, here illustrating the lecture to the first Medicolegal Seminar at the University with the aid of a skeleton.

sies are scheduled, law students are called—two at a time—to view the autopsy.

"This course is not just the vehicle for fashioning another tool for the lawyer to use in his practice, however," Powers cautioned. "I feel this is something that will do more in the long run to clear up some of the misunderstandings that now exist between the professions of medicine and law than perhaps any other single thing."

Not only does the law student see the exacting nature of the work undertaken by doctors, but he comes to understand the demands placed upon his time and efforts by the calling he has chosen.

Only once to date has a lecturer not been able to meet with the seminar. This cancellation served to emphasize the suddenness of demands upon physicians. The lecturer was in surgery, and the reason for his unavoidable absence was explained to the class.

Powers' enthusiasm for the venture is shared by the faculty of the College of Medicine. This represents a logical extension of the philosophy that underlies the entire program of the college. From the start it has been emphasized that the graduates of the Colleges of Medicine, Nursing, Health Related Services and Pharmacy are going to become a health team in practice and the cooperation and understanding that make a team are established in undergraduate training at the seminars are bringing together men and women University of Florida. Now, interdisciplinary who can cooperate in the pursuit of their different professions.

Florida Academy of General Practice Plans Big Fall Assembly

Dr. Temple S. Fay, of Philadelphia, Dr. Leon Unger, of Chicago, and Dr. Theodore A. Watters, of New Orleans, will be among the featured out-of-state speakers on the scientific program of the Eleventh Annual Scientific Assembly of the Florida Academy of General Practice this fall, it was announced by Dr. R. R. Killinger, General Chairman. Other well known physicians on the program include Dr. Joseph R. Shaeffer, of San Antonio, Dr. James G. Lyerly, of Jacksonville, Dr. Lewis A. Shepperd, of Miami, and Dr. Peter F. Regan, Head of the Department of Psychiatry, College of Medicine, University of Florida.

Dr. Watters and Dr. Regan will discuss basic concepts in teaching nonpsychiatric physicians



Dr. Fay



Dr. Unger



Dr. Watters

management of psychiatric problems, and will cover the application of psychiatric principles in general practice and in specific problems. Dr. Watters is known particularly for his approach to courses in psychiatry for general practitioners, which he has conducted in the New Orleans area for over five years.

Dr. Fay, formerly Professor and Head of the Departments of Neurosurgery and Neurology at Temple University School of Medicine, is now President of the Philadelphia Neurosurgical Society. He will cover practical considerations in diagnostic screening of cerebral accidents and chronic types of paralysis and recent clinical tests for establishing diagnosis in neuromuscular disorders. In much the same field, Dr. Lyerly, formerly Assistant Professor of Neurological Surgery at the Medical College of Virginia, will present a paper on "Strokes, Subdural Hematoma and Brain Tumor."

Dr. Unger, Associate Professor of Medicine, Northwestern University Medical School, Member of the American Academy of Allergy and American College of Allergists, will speak twice on subjects of special interest to the general practitioner in his field.

The Eleventh Annual Scientific Assembly will be held at the Hotel Robert Meyer, Jacksonville, October 21 and 22, 1960.

Glaucoma Detection Programs

At the recent annual meeting of the Florida Medical Association, the House of Delegates adopted a supplementary report of the Committee on Conservation of Vision pertaining to glaucoma screening programs in Florida. This report specified that procedures and standards were to be recommended by the Florida Society of Ophthalmology and Otolaryngology. A resolution, setting forth in detail the manner in which programs for glaucoma detection should be carried out, was accordingly adopted by the Florida Society of Ophthalmology and Otolaryngology at its annual meeting on April 10, 1960, and was submitted for publication in The Journal by Dr. Marion W. Hester, of Lakeland, Chairman of the Association's Committee. The resolution follows:

Resolution

The Florida Society of Ophthalmology and Otolaryngology will cooperate with reliable and interested lay groups who wish to sponsor screening programs for detection of chronic glaucoma.

This Society believes that such programs in our state should be under the supervision of its Ophthalmologist members. The program should best be conducted as a joint effort of the County Medical Society and the County Health Officer working with the sponsoring lay group. In urban areas, actual screening tests might be done by volunteer Ophthalmologists or by registered nurses, trained by Ophthalmologists and working under medical supervision. In rural areas, actual screening tests might be done by volunteer general physician members of the local County Medical Society or by registered nurses working under medical supervision. In these rural areas arrangements should be made by the Ophthalmologists committee in charge, to have one of the nearest Ophthalmologists supervise the program and give aid or advice when needed.

These programs should generally be limited to screening people over 40 years of age. People with a history of glaucoma should be excluded from testing. Such programs should generally be limited to one purpose, the detection of glaucoma. These programs should be for screening only, leaving examinations and diagnosis for later determination. Testing should be simple. In most instances it should consist of a tonometric reading of each eye and visual acuity in each eye with glasses, if worn. The 20/40 line only from a Snellen chart should be used and the subjects are recorded as reading or not reading the 20/40 line. Tonometer readings should be made with the 7.5 gram weight. A scale reading of 5 or less should be regarded as a glaucoma suspect and a scale reading of more than 5 should be regarded as normal. A reading of 5 with the 7.5 gram weight corresponds to a reading of 27.35 using the new calibration scale. Patients should be classified as:

1. No evidence of glaucoma.
2. Glaucoma suspect.
3. Evidence of other eye abnormality.

Glaucoma suspects should be referred to the Ophthalmologist of their choice for examination and treatment. If they have no choice, they should be referred to the yellow pages of the phone book under Ophthalmologist. For those areas without such a listing, the committee should have a list of available Ophthalmologists which may be handed out. People with evidence of other eye abnormality should be told that they should be examined to see if vision can be improved. For those abnormal cases who cannot afford private care, the sponsoring lay organization may be able to assume the cost of examination. Some cases may be able to receive service through the Florida Council for the Blind.

Care should be taken with borderline cases of increased pressure. A scale reading of 5 or just under, should be carefully rechecked for accuracy. Many of these borderline cases will be found *not* to have glaucoma. When they have to pay a considerable sum for examination and lose time from work for no apparent good reason, they become incensed at the whole program.

A minimum amount of equipment is needed for such a program. A Snellen chart 20/40 line, tonometers, some means of tonometer sterilization, topical anesthetic such as tetracaine ½% and a place for the subject to recline will suffice. It is recognized that considerable equipment may be desirable in the more elaborate programs carried out under the auspices of medical schools, but it is unnecessary for the success of the screening program.

A printed slip with the screening result and necessary instructions may be handed to each subject. A fact sheet summarizing information on glaucoma should also be given each subject. Some centers may prefer to use the Glaucoma Pamphlets which can be obtained from the National Society For the Prevention of Blindness or the Florida Council for the Blind. A small individual record card should be kept on each person screened summarizing the information obtained. These records should remain in the custody of the Ophthalmologist committee.

Unrestricted radio, television and newspaper publicity has been found undesirable. In some instances the interest generated in the program has caused automobile traffic jams, parking problems and swamping of glaucoma screening facilities. It has worked better to do the testing by appointment, allowing certain groups so many reserved appointments per hour. Publicity must be controlled by joint agreement between the local county medical society and the sponsoring lay organization.

Blue Shield Board of Directors

Presented here is a group of dedicated persons, most of whom are physicians, so that members of the Association may better know those who generously give of their time and ability for the welfare of the public and for the advancement of the medical profession—the Blue Shield Board of Directors. These are the men whom the doctors of Florida have selected to direct and supervise their Blue Shield Plan. Their selfless service is hereby recorded for permanency in these pages of The Journal.

Leigh F Robinson, M.D.
Honorary Chairman of the Board
Ft. Lauderdale

Father of the Blue Shield Program in Florida and Dean of the Board, Dr. Robinson, a practicing surgeon, received his medical training at Jefferson Medical College of Philadelphia, and has devoted the major portion of his professional career to serving the people of Florida. Without his foresight, dedication and perseverance the inception of Blue Shield in this state would have been unnecessarily delayed.

Russell B. Carson, M.D., President
Ft. Lauderdale

A veteran in Blue Shield service, Dr. Carson has been President five of his six years as a member of the Board. A graduate of the Tulane University School of Medicine, he limits his practice to the field of urology. When the demands of his many activities permit, he finds relaxation in cruising the waterways of the area with family and friends.



Dr. Robinson



Dr. Carson

H. P. Osborne Sr.
Honorary Member of the Board
Jacksonville

Legal counsel for Blue Shield and Blue Cross since their beginning in Florida, and a member of the Blue Shield Board since 1947, Mr. Osborne has the distinction of holding the number one contract in the state. He is recognized as a worthy opponent on the fairways as well as in the halls of justice.

Jere W. Annis, M.D., Vice President
Lakeland

Exceptionally energetic in public service activities and professional organizations, Dr. Annis, past president of the Florida Medical Association, serves Blue Shield as an officer and on numerous committees. He received his medical degree from the University of Minnesota Medical School and held a fellowship at the Mayo Clinic from 1935 to 1938. He practices internal medicine at the Watson Clinic in Lakeland, yet finds time to uphold his reputation as a marksman with rifle or pistol.



Mr. Osborne



Dr. Annis

Henry J. Babers, M.D.
Gainesville

A native Floridian and graduate of the University of Florida, Dr. Babers obtained his medical training at the Cornell University Medical College. Prior to his election to the Board he was chairman of the Florida Medical Association's Advisory Committee to Blue Shield (Committee of 17), which he organized and guided from fledgling status to high esteem among the physicians of Florida. When not wielding a scalpel, Dr. Babers likes to tour the fairways or relax at his restful cabin on the river.

William Hollis
Lakeland

Vice President and director of Publix Super Markets, Inc., Mr. Hollis give generously of his time in service to the public and the medical profession through



Dr. Babers



Mr. Hollis



Dr. Hurt



Mr. Miller



Dr. Milton



Mr. Osborne



Mr. Palmer



Dr. Roberts



Dr. Rogers



Mr. Rose

Blue Shield. Thirty-two years ago he arrived in Florida from his native Georgia to begin a successful business career. With not too much time for leisure he does occasionally hunt, fish or play a round of golf.

Floyd K. Hurt, M.D., Treasurer
Jacksonville

Currently president of the Duval County Medical Society and practicing roentgenologist, Dr. Hurt came to Florida twenty-two years ago after receiving medical training at the University of Virginia School of Medicine. Although he is not entirely unfamiliar with outdoor activities, his number one avocation is painting. He is a member of the American Physician's Art Association.

C. DeWitt Miller
Orlando

Mr. Miller doubles in brass not only serving on the Blue Shield Board but also as president of Blue Cross of Florida, Inc., a Plan which he helped to organize. A retired businessman, Mr. Miller points with pride to nearly a half century of service to guests in his hotel and the citizens of his community.

John D. Milton, M.D.
Miami

Son of a Methodist minister and graduate of the Emory University School of Medicine, this native of neighboring Georgia came to Florida thirty-five years ago to practice obstetrics and gynecology in his adopted Miami. He served as president of the Florida Medical Association in 1955-1956. Active in community and professional organizations, he relaxes occasionally with golf club or rod and reel.

H. P. Osborne Jr.
Jacksonville

Like father, like son, Mr. Osborne is an attorney who thoroughly believes in the service principle for protection against the expenses of illness. A graduate of the Harvard Law School, he is in legal practice with his father in Jacksonville. Again, like father, he shoots a highly competitive game of golf.

George S. Palmer, M.D.
Tallahassee

A lad who spent his boyhood days among the hills of the Capital City now utilizes the training that he obtained at the Johns Hopkins University School of Medicine to see that today's children in Tallahassee are kept healthy that they, too, may enjoy those same hills. Devoted to service to Blue Shield and his profession, Dr. Palmer also is particularly partial to a beautiful lawn.

William C. Roberts, M.D.
Panama City

Dr. Roberts, native of neighboring Alabama, came to Florida some twenty-eight years ago, shortly after re-receiving his degree in medicine from the University of Tennessee College of Medicine. A past president of the Florida Medical Association, he prefers to do most of his practice in the fields of obstetrics and gynecology. An outdoor enthusiast, he has another specialty, champion bird dogs.

Hunter B. Rogers, M.D.
Miami

A degree from the University of Georgia School of Medicine led to the establishment of an extensive prac-



Mr. Saarinen



Mr. Schroder



Dr. Stage



Dr. Steward



Dr. White



Judge Willis



Dr. Marr

tice in internal medicine in Miami for Dr. Rogers. Community and professional activities claim most of his time, leaving all too little for his side ventures into horticulture.

Carl G. Rose
Ocala

Engaged in the business of road construction and lime rock quarrying, Mr. Rose is president and general manager of the Ocala Lime Rock Company and president of the Marion County Construction Company. A native of Indiana, he has been in Florida forty-four years. He is better known as a breeder of thoroughbred horses at his internationally famous Rosemere Farms on the outskirts of Ocala.

Arthur G. Saarinen
Ft. Lauderdale

It is of inestimable value to have on the Blue Shield Board a member well versed in all phases of finance. Mr. Saarinen is president of the Broward National Bank, vice president and director of the Ft. Lauderdale National Bank and a director of the Coral Ridge National Bank. A native Floridian, he likes to spend off hours in his wood-working shop or in his garden.

H. A. Schroder, Executive Director
Jacksonville

As Executive Director and Assistant Secretary, Mr. Schroder efficiently and effectively carries out the policies and directives of the Board. Under his leadership Blue Shield of Florida has grown from a struggling debt-ridden neophyte at the time he first appeared on the scene in 1946 to a sound organization with a membership of over 800,000, which paid out over $8,000,000 to Florida physicians in 1959. In spite of many weekends taken up with business meetings he still maintains a low handicap and relishes the sharp bargaining at the first tee.

John T. Stage, M.D., Secretary
Jacksonville

Dr. Stage is a graduate of the Ohio State University College of Medicine, and a practicing anesthesiologist in Jacksonville. He has been in Florida for twelve years. An amateur photographer, he also enjoys relaxing to the strains of high fidelity recordings.

W. Dean Steward, M.D.
Orlando

Born, reared and educated in Georgia, Dr. Steward came to Florida fourteen years ago immediately after receiving his medical degree from the Medical College of Georgia in his home town of Augusta. Active in community and professional organizations, he specializes in orchid growing during hours away from practice.

Millard White, M.D.
Sarasota

An alumnus of the University of Florida, Dr. White received his medical training at Duke University School of Medicine. He now resides in Sarasota, limiting his practice to the field of pathology. His recreational interests incline toward the more creative activities of photography, writing and music.

The Honorable Ben C. Willis
Tallahassee

Judge of the Second Judicial Circuit of Florida, this University of Florida trained attorney still finds time to devote to Board meetings and to community activities. Judge Willis is a Floridian with confidence in

the future of his native state. He is a recognized historian with Florida and local history his primary interest.

Norval M. Marr, M.D.
St. Petersburg

A graduate of the University of Cincinnati College of Medicine, Dr. Marr practices internal medicine in St. Petersburg. In his almost 35 years of membership in the Florida Medical Association he has found time to serve on many important committees and as a member of the Board of Governors. In addition to those good offices, he has served the public and doctors of Florida as a Blue Shield Director three years and has just begun a second three year term. To fulfill his desire for travel at home and abroad, he has just completed a tour of Europe.

Annotated Bibliography On Retrolental Fibroplasia*

In response to a number of inquiries, the National Society for the Prevention of Blindness has compiled an annotated bibliography on the relationship of oxygen therapy to retrolental fibroplasia. These references are set out in chronological order to show when it was that knowledge of the cause and prevention of this disease became available to the medical profession. While this bibliography is by no means a complete listing of the articles that have been published on this subject, it indicates that numerous articles have appeared in the literature pertaining to the role of oxygen in the etiology of retrolental fibroplasia. The bibliography follows:

* Commonly abbreviated as RLF.

1. Campbell, K.: Intensive oxygen therapy as a possible cause of retrolental fibroplasia: a clinical approach, Med. J. Australia 2:48 (July) 1951.
2. Crosse, V. M., and Evans, P. J.: Prevention of retrolental fibroplasia, A.M.A. Arch. Ophth. 48:83 (July) 1952.
   "In our view, supported by the history of the disease in England since 1946, by our own experience, and by comparison with the experiences in other centers in the country, it is right to draw attention to the dangers of the use of too much oxygen and to its administration for too long a period. . . ."
3. Patz, A., and others: Studies on the effect of high oxygen administration in retrolental fibroplasia: I. Nursery observations, Am. J. Ophth. 35:1248 (Sept.) 1952.
   Study in Gallinger Municipal Hospital, Washington, D. C., was aided by grants from National Institute of Neurological Diseases and Blindness and District of Columbia Society for the Prevention of Blindness. The results of the first of a three year controlled oxygen nursery study are cited. Authors conclude that there are now sufficient data to question the advisability of the "routine" use of prolonged high oxygen concentrations in the nursery.
4. Editorial: Retrolental fibroplasia and oxygen, J. Ped. 44:122, 1954.
   ". . . there is a growing feeling that oxygen should not be given routinely to the premature infant, but reserved for individualized cases of asphyxia and further, it should be used in as low a concentration as possible and for as short a time as possible."
5. Lanman, J. T., and others: Retrolental fibroplasia and oxygen therapy, J.A.M.A. 153:223 (May 15) 1954.
   Report of research at Bellevue Hospital, New York, concluding that the authors believed the disease to be directly related to excessive oxygen and felt that it could be controlled by severely restricting oxygen administration to premature infants.
6. Letourneau, Charles U.: Hospitals 28:109 (Aug.) 1954.
   The author (assistant director of American Hospital Association and secretary of Association's Council on Professional Practice) stated in this medical review: "We must not allow premature infants to be exposed to high concentration of oxygen routinely. Concentration in cases of emergency up to 40 per cent is allowable, but having prescribed, the physician has discharged his obligation. The rest is up to the hospital to administer the treatment as prescribed . . . Despite the reading on the flow-meter, the oxygen may not be delivered as the doctor prescribed it. It must be checked by an adequate analyzer. . . . The hospital administrator must bear the responsibility for preventing retrolental fibroplasia no less than the physician and the scientist. We have a special part to play in preventing this dreadful disease, and each of us must make certain that he has used all the technical, scientific and professional knowledge available to him."
7. Hepner, W. R.: Retrolental fibroplasia—Current notes, A.M.A. J. Dis. Child. 88:356 (Sept.) 1954.
   On page 359, under heading "Recommendations," the author said: "Oxygen tends to be overused, rather than underused, both in concentration and in duration of therapy. After the first two or three days, concentrations greater than 40 per cent are rarely indicated, and after two or three weeks, need for more than room air is uncommon."
8. Nat. Soc. Prev. Blindness: Communication (Oct. 29, 1954) to state and city directors of maternal and child health programs; directors, maternal and child health, schools of public health.
   Referred to cooperative research study in 18 hospitals, reported by Kinsey at Symposium on Retrolental Fibroplasia held during October 1954 American Academy of Ophthalmology and Otolaryngology meeting. Consensus of participants, as stated by Algernon B. Reese, M.D., chairman: that routine administration of oxygen to premature babies be discontinued; that it be given only if there be cyanosis or respiratory disease, that in such cases the concentration inside the incubator be kept below 40 per cent as measured by an oxygen analyzer, and that oxygen therapy be discontinued as soon as respiratory distress is relieved. (See reference No. 17)
9. Rothmund, H. I. M., and others: A field study of retrolental fibroplasia in Maryland, Pediatrics 14:455 (Nov.) 1954.
   The authors stated that a recent series of papers by Patz, Ashton, Lanman and others "have indicated that oxygen is an etiologic factor."
10. Abstract of article from Lancet, J.A.M.A. 156:1102 (Nov. 13) 1954.
    Reported striking correlation of oxygen administration to premature babies and the occurrence of retrolental fibroplasia.
11. Editorial, Prematurity, oxygen, and retrolental fibroplasia, J.A.M.A. 157:449 (Jan. 29) 1955.
    "In the present state of knowledge, there is certainly no reason to deny small premature infants the benefits of incubator care or of additional

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oxygen in the amount and duration indicated by relief of cyanosis. And, since retrolental fibroplasia is essentially limited to infants of less than 2,267.9 grm. (5 lb.), there need be no fear of disturbing the eyes of term infants by the oxygen therapy so frequently required for their pulmonary and circulatory disturbances. On the other hand, the evidence is now strong that the exposure of infants to oxygen for even several days is associated with increased incidence of retrolental fibroplasia. Thus, the physician caring for a premature infant should steer a course between preventable anoxia endangering survival on the one hand and the ophthalmologic hazards of unnecessary use of oxygen on the other."

12. Smith, Clement A.: Oxygen and retrolental fibroplasia, Mod. Hosp. 84:49 (Feb.) 1955.
The author discussed various studies indicating the relationship between oxygen and retrolental fibroplasia, and pointed out that the statistics on the 18-hospitals study reported by Kinsey at a meeting of the American Academy of Ophthalmology and Otolaryngology in September 1954, were highly significant in showing the relationship between prolonged high-oxygen administration and the disease. However, he did not make a strong recommendation as to methods of prevention.

13. Editorial, The overuse of oxygen and retrolental fibroplasia, J. Ped. 46:252 (Feb.) 1955.
"If currently available information is disregarded and an infant becomes blind, the burden that lies on the physician and the hospital is unpleasant to contemplate. The conclusion is obvious that discriminate and limited use of oxygen in premature babies is now mandatory."

14. Engle, Mary A., and Levine, S. Z.: Response of small premature infants to restriction of supplementary oxygen, A.M.A. J. Dis. Child. 89:316 (Mar.) 1955.
The authors, reporting studies at New York Hospital—Cornell Medical Center, concluded: "There were no detectable late ill effects from the early termination of oxygen administration. It would seem that the administration of oxygen to premature infants of low birth weight as a routine procedure is not necessary."

15. Lanman, J. T.: The control of oxygen therapy for the prevention of retrolental fibroplasia, J. Ped. 46: 365 (Mar.) 1955.
"In summary, the proper control of oxygen use means first its total elimination except for times of clinically demonstrable need. It should then be given for as brief a time as possible at concentrations below 40 per cent." The author then went on to say how to control the concentration.

16. Kinsey, V. E.: Letter to the editor, Pediatrics 18: 511 (Sept.) 1956.
"In view of the positive evidence indicating that even relatively short exposures to oxygen are associated with RLF, even though the concentration is kept below 40%, and the paucity of evidence that there is any critical concentration below which RLF is markedly reduced in incidence, I believe that merely restricting the concentration of oxygen, without stringently reducing the duration in oxygen, may result in unnecessary cases of RLF. Certainly, the emphasis should be placed on restricting the duration in oxygen to an absolute minimum consistent with the clinical indications of anoxia irrespective of the concentration of oxygen administered."

17. Kinsey, V. Everett, and others: Retrolental fibroplasia—Cooperative study of retrolental fibroplasia and the use of oxygen, A.M.A. Arch. Ophthal. 56: 481 (Oct.) 1956.
The authors' recommendations: "The length of time a premature infant, particularly an infant of multiple birth, is kept in an environment containing oxygen in concentrations in excess of that of air should be kept to an absolute minimum, consistent with the clinical indications of anoxia. When oxygen therapy is clearly required, it should be prescribed on an hourly basis and the concentration should be as low as possible."

18. Patz, Arnall: The role of oxygen in retrolental fibroplasia—E. Mead Johnson award address, Pediatrics 19:504 (Mar.) 1957.
"These clinical and experimental data justify recommendations for a rigid supervision of oxygen administration to the premature infant to avoid any unnecessary overuse of this potentially toxic agent."

Mail Order Prescription Schemes

It may be a long time before the patient who just walked out of your office with an important prescription in his pocket ever gets around to taking the needed medication—the reason—mail order prescription schemes. Now being heavily promoted all across the nation, these schemes center their publicity on cut-rate prescription prices.

Here, for example, is what might happen to your patient.

Instead of taking his prescription to his community pharmacist to be filled that day, he drops it into the mail to one of these operations perhaps a thousand miles away. From seven to 10 days later, the filled prescription comes back, perhaps too late to do the job for which it was originally intended.

Your patient in the meantime, still experiencing the symptoms which prompted his visit to you in the first place, attempts to tide himself over until the prescription arrives by applying some sort of self medication which may give him temporary relief and at the same time lessen his understanding of the importance of your diagnosis and the drugs you prescribed.

Not only are dangerous delays characteristic of the mail order mechanism, but the public is also denied the complete services it has a right to expect from any pharmacist in any pharmacy. As a regular practice, mail order operators refuse prescriptions containing narcotic drugs. Most patients have no knowledge of what is and what is not a narcotic drug; and therefore any warnings by the mail order house that it will not accept prescriptions for narcotic drugs become meaningless. The patient, after exposure to unnecessary delay, discovers that his prescription is only obtainable from his community pharmacy.

Prescriptions for narcotics are not the only ones which mail order houses refuse to dispense.

There are classes of prescriptions which are being refused by mail order operators for their own convenience, especially prescriptions which require compounding. Both the ethics and traditions of the pharmaceutical profession demand that a pharmacist make every effort possible to dispense promptly every prescription he receives regardless of the amount of professional attention required.

Because these depots operate on an impersonal assembly line basis in a jurisdiction where only the supervision—rather than the actual dispensing—by pharmacists is required, the danger of dispensing errors is increased. Moreover, by operating outside the states in which the prescription was originally written, these houses deny the patient the protection he has a right to expect from his own state laws governing the practice of pharmacy.

Another area in which the public is being misled is illustrated by quoting from a full page advertisement which a District of Columbia mail order operator inserted in The Philadelphia Inquirer of Sunday, April 3, 1960:

> YOUR PRESCRIPTIONS ARE COMPOUNDED BY REGISTERED PHARMACISTS!
>
> Our registered pharmacists compound your prescriptions in ultra-modern, regularly inspected pharmacies—using the finest, freshest nationally known ingredients.
>
> YOUR ORDER IS FILLED IMMEDIATELY TO ASSURE YOU OF FRESHNESS!
>
> The same day we receive your prescriptions—our pharmacists fill them and mail them out. This assures you of the freshness of every medicine you receive from us. And, of course, with our volume business and volume turnover, our shelves of vitamins and chemical ingredients are constantly replenished with fresh items.

After the publication of this advertisement, it was revealed that the premises described consisted of nothing more than an empty room without any inventory, fixtures, or pharmaceutical equipment. This advertisement was refused by two other large circulation newspapers, and the matter has been called to the attention of the Federal Trade Commission.

Perhaps as important as anything else to the medical profession is the fact that such schemes make it convenient for certain kinds of practitioners, unauthorized to prescribe in their own states, to write prescriptions that will be filled by these distant operations. The geographical separation between prescriber and dispenser makes it virtually impossible, and impractical for these operators, to check the source or to offer professional advice to the patient when he receives his medication.

The greatest opportunity for mail order promotion has been the geriatric market, where public attention has been mostly concentrated in recent months.

A host of other unanswered questions comes to mind when prescriptions are ordered from these assembly line outfits. For example, how can we safely assume that long distance dispensing will be as the prescriber intended? Is the way paved for substitution? Has the prescription been compounded under sanitary conditions?

The District of Columbia, where standards for pharmaceutical practice are based on an antiquated 1906 act of the Congress, has become the haven for mail order operators. One of these Washington-based firms was recently brought bebefore Corporation Counsel of the District of Columbia. The investigating officer described the premises as "without facilities for compounding prescriptions," and noted further that the only "sink was located in the rear of the store by going through a room that had waste paper for wrapping and packaging all over the place and the room where the sink was located proved to be filthy and the sink itself was corroded and stained and in a filthy condition."

That these mail order prescription schemes are truly a menace to public health was emphasized by a statement made by Dr. George M. Fister, a member of the American Medical Association Board of Trustees, in an address at the recent meeting of the American Pharmaceutical Association House of Delegates. Physicians, he noted, can easily warn their patients of the many flaws in these dangerous mail order operations. He went on to condemn the mail order schemes as "one of the gravest problems" facing the health field today.

A physician for more than 30 years, Dr. Fister said that he does his best to discourage any patients from sending prescriptions to a mail order operation. "The personal touch is still essential," he commented. America's high standard of medical care was "founded on this firm foundation of personal service, and we would be foolish indeed not to preserve it."

The development of highly concentrated synthetic drugs, purified natural products, potent dosage forms and special needs in storage and dis-

pensing all have created new problems of drug supervision, regulation and administration. The pharmacy and drug laws of each state are designed to protect citizens from the effects of ignorance and incompetency in these matters which are beyond individual patient control.

The American Pharmaceutical Association has launched an educational campaign to inform all members of the medical profession about the inherent dangers in mail order prescription operations. The national professional society is also supporting H.R. 10597, which will bring to the District of Columbia a modern pharmacy act.

At an emergency meeting in Washington, D. C., haven of the prescription-by-mail operators, Dr. William S. Apple, APhA Secretary, declared: "If this personal pharmacist-patient relationship is not preserved, the next break in the chain will inevitably be the elimination of the physician as the diagnostician and substitution of the mail order purveyor as the prescriber. The only call on the physician will be to write the death certificate. Individual acceptance of professional responsibility by all members of the medical team can quickly put an end to the development of centralized mail order prescription depots."

If mail order prescription hazards are to be fully recognized, the medical profession must join with other members of the health team by reacting quickly and in a positive manner. Otherwise, the public will be misled into believing that an impersonal centralized mail order method is an acceptable substitute for sound community medical-pharmaceutical service.

OTHERS ARE SAYING

Good Public Relations

Over the past ten years or so the *science* of medicine has made tremendous progress. During this same period of time the prestige of the doctor as a humanitarian has declined, at least in the public eye.

I feel that part of our prestige has been lost because some of us have forgotten that there are times when our mere presence *is essential*—even if there is nothing we can do from a scientific point of view. A few of these cases come to mind.

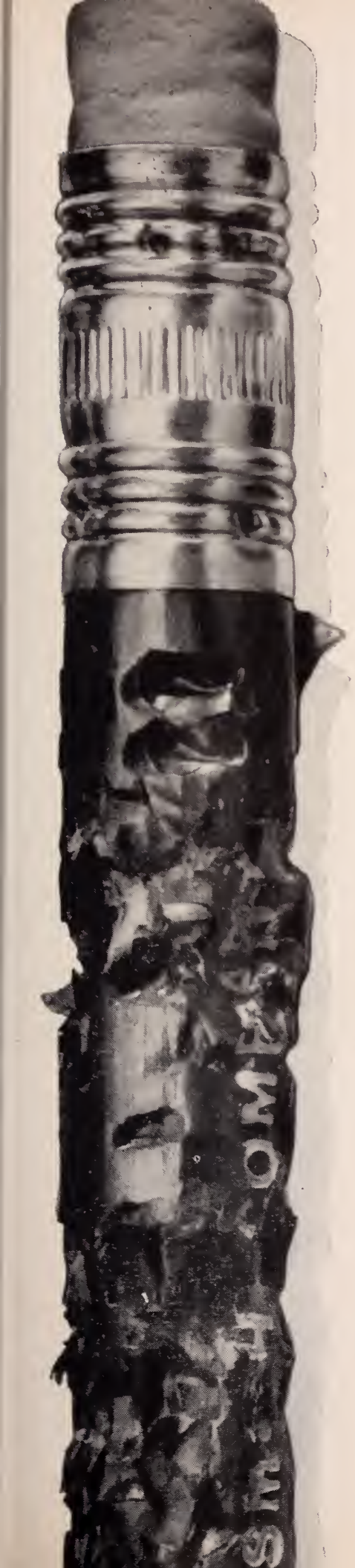
As most of you probably know, it is now necessary for a physician to pronounce a patient dead when death takes place in the home or in a nursing home. Some of us when called in such a case do not go, but merely say, "Call the undertaker." We have probably not considered what effect such a statement has on the family and what it means in such a situation. It means that the ambulance driver has to notify the police; the police have to arrive at the scene of the death and then transport the body to the emergency room of one of the hospitals to be pronounced dead. At such a time such an experience can be very upsetting to the family. You can prevent it by your presence.

Another instance along this line is when some of us operate on a patient and, finding that he is unresectable, send him home or to a nursing home. We feel that he is no longer our responsibility. As you probably know, it is very hard to get a doctor to come to a nursing home to see one of these patients. I feel that such a patient should remain our responsibility—to follow that patient through to the end, whether he is operable or inoperable, whether he is in a nursing home or in a private home. We should be there at the time of death, or available if death should ensue.

Another instance—many members of our society are working more and more in only one hospital and refuse to see patients in a hospital other than that of their choice. It is very poor public relations for a physician to refuse to see or treat a patient just because he is admitted (by *his* own choice) to another hospital—particularly if the patient has been seen by the physician for a number of years. It is not fair to the patient to force him to change doctors in the middle of the stream, and it is undesirable, to say the least, for the physician to abandon the case unless he himself makes arrangements in advance for another physician to take over.

In the midst of all of our scientific progress, let us not lose sight of the fact that the patient is something more than a case. If we wish to improve our "public relations," we should bear in mind that it is instances like these which, properly handled, make for "good public relations."

We still have an opportunity to regain our prestige. Last month, the Ways and Means Committee turned down, 17 to 8, a move to include the Forand measure in a bill making other changes in the Social Security program. Our fight is not over by any means, and our actions in dealing with patients and their families are becoming more and more important.



when you see signs of anxiety-tension specify

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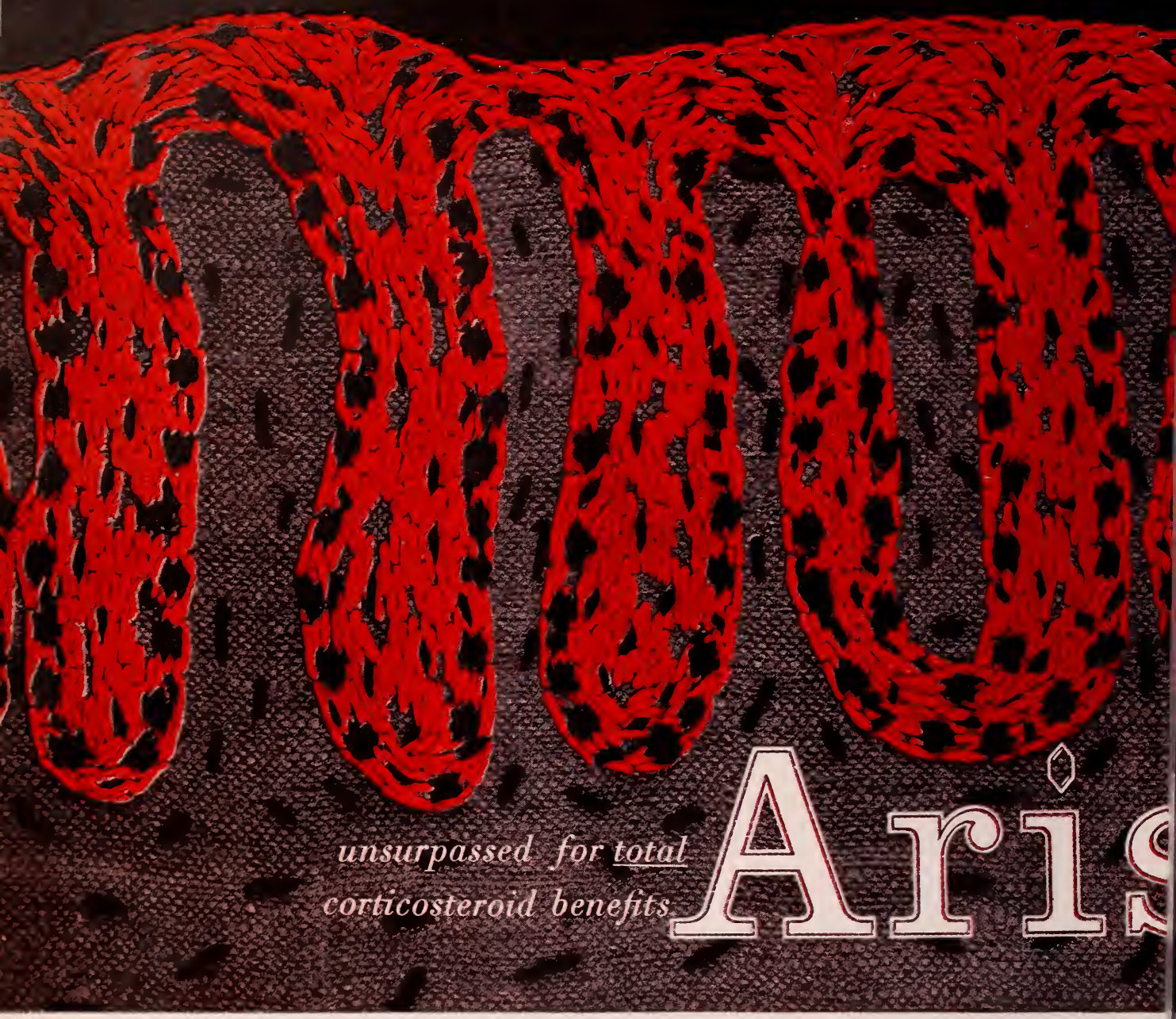
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with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

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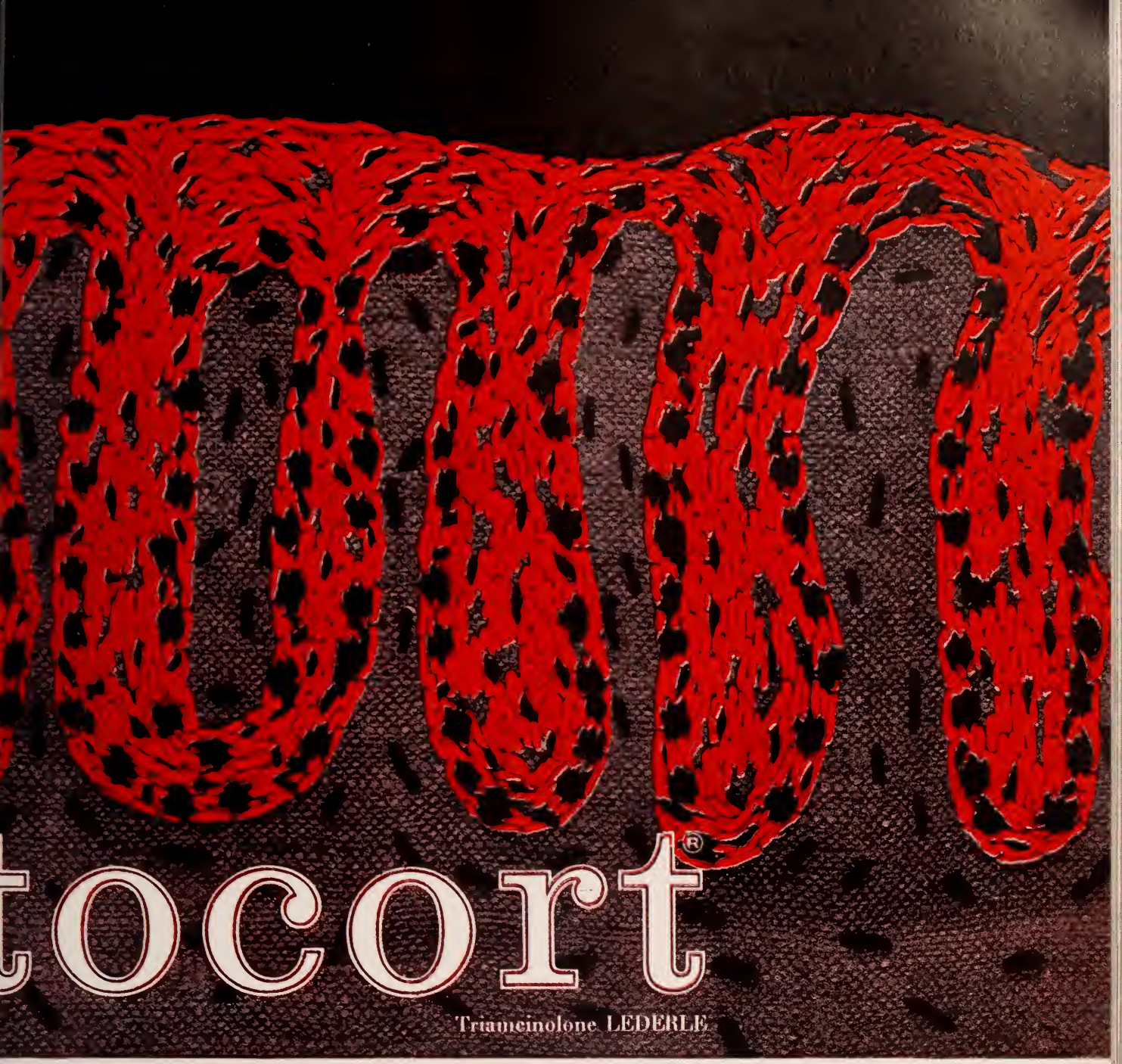
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Substantiated by published reports of leading clinicians

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- **minimal disturbanc** of the patient's chemical and psychi balance[1,4-18]



At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:

- **freedom from salt and water retention**
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- **euphoria and depression rare**
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- **low incidence of peptic ulcer**
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Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

Supplied: 1 mg. scored tablets (yellow); 2 mg. scored tablets (pink); 4 mg. scored tablets (white); 16 mg. scored tablets (white).

Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.

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We can't buy or pay for "good public relations"; we make them by our own actions.

Linus W. Hewit, M.D.
The Bulletin
Hillsborough County Medical Association
May 1960

STATE NEWS ITEMS

Dr. Lloyd R. Newhouser of Miami has been installed as president of the Florida Association of Blood Banks, and Dr. John A. Shively of Bradenton as vice president. Mrs. Dorothy C. Smith of Jacksonville has been chosen president-elect. In addition to Drs. Newhouser and Shively, other physicians attending the recent annual meeting held at Clearwater included Drs. James J. Griffitts, Miami; Jacob Neber, Miami Beach; Newton W. Larkum, Fort Myers; A. Ralph Monaco, Panama City; Robert E. Klein, Gainesville; Louis E. Pohlman, Orlando; Gerard H. Hilbert, Pensacola; Clarence W. Ketchum, Tallahassee; James B. Leonard, Clearwater; James N. Patterson, Tampa; John B. Ross, Jacksonville, and Donald W. Smith, Miami.

Drs. Robert N. Wilcox and Alvan G. Foraker of Jacksonville presented papers at the International Congress of Clinical Pathology held in June in Madrid. Each also lectured in the Gynecology Clinic at the University of Madrid. While abroad, Dr. Foraker presented addresses in the Department of Obstetrics and Gynecology, University of Barcelona, and the Department of Pathology, University of Lisbon.

Dr. Louis M. Orr of Orlando, President of the American Medical Association, addressed the House of Delegates of the Medical Society of the State of New York May 9 during the 154th annual meeting of the Society held in New York City.

Dr. Nathaniel M. Levin, Associate Clinical Professor of Otolaryngology at the University of Miami School of Medicine, directed a postgraduate course in esophageal speech and organic voice problems at the University June 20-24.

Dr. James N. Patterson of Tampa administered the examinations of the American Board of Pathology at the University of Tennessee Col-



lege of Medicine at Memphis late in April and also attended meetings of the International Academy of Pathology and the American Association of Pathologists and Bacteriologists.

Dr. Jere W. Annis of Lakeland discussed "Heart Disease" at the May 11 meeting of the Rotary Club in Bartow. In April, Dr. Annis was featured speaker at the joint dinner meeting of th Highlands County Medical Society and its Woman's Auxiliary held at Avon Park.

Dr. Wilson T. Sowder of Jacksonville, state health officer, has been attending the 13th World Health Assembly held in Geneva, Switzerland, as one of eleven advisors to the United States Delegation by appointment of President Eisenhower. While abroad Dr. Sowder visited hospitals and clinics in France and Italy.

Dr. Franklin J. Evans of Coral Gables and Dr. Lawrence V. Hastings of Miami participated in the scientific program of the annual convention of the American Board of Legal Medicine held June 12 at Miami Beach. Dr. Evans presented a paper entitled "Malpractice Suits Based Upon Alleged Experimentation: A Legal Paradox," and Dr. Hastings discussed "The Medical Preparation and Trial of a Negligence Action."

A postgraduate course in laryngology and bronchoesophagology has been scheduled by the Department of Otolaryngology, University of Illinois College of Medicine, for October 17-29. Registration will be limited to 15 physicians. Information may be obtained by writing the College at 1853 West Polk Street, Chicago 12, Ill.

The Tennessee Valley Medical Assembly is being held September 26-27 in the Read House at Chattanooga, Tenn. Sponsor is the Chattanooga and Hamilton County Medical Society.

Dr. Sanford Cobb of Miami discussed "Muscle Relaxants and Consciousness" as a part of the program of the Anesthesia Section of the Southeastern Hospital Conference held at Miami Beach early in May.

Dr. Allen Shepard of Key West began a residency in anesthesia July 1 at the Charity Hospital in New Orleans.

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The annual course in postgraduate gastroenterology presented by the American College of Gastroenterology has been scheduled for October 27-29 at the Bellevue-Stratford Hotel in Philadelphia. In addition to individual papers, there will be a clinical session at the Albert Einstein Medical Center, panel discussions and clinicopathologic conferences. Information is available from the College at 33 West 60th Street, New York 23, N. Y.

Dr. Paul A. Tanner Jr. of Auburndale has been participating in the program of training for members of the rescue squad of the Auburndale Fire Department.

Dr. Ernest A. Reiner of Tampa has been elected vice president of the Hillsborough County Heart Association, and Dr. Louis E. Cimino of Tampa chairman of the board of directors.

Dr. Carlos P. Lamar of Miami presented the Eighth Annual B. B. Weinstein Lecture at the 33rd annual banquet, Medical Historical Society of Tulane University, New Orleans, May 20. The title of Dr. Lamar's address was "Comments on the History of Diabetes."

COMPONENT SOCIETY NOTES

Duval

The Tetanus Immunization Campaign conducted by the Public Health Committee of the Duval County Medical Society during February and March resulted in a large percentage increase in tetanus immunization in clinics and a continuing increased demand although the campaign is over. Dr. Hugh A. Carithers is chairman of the Committee and Dr. Lillian C. Mark is co-chairman. Other members include Drs. David O. Booher, Stephen P. Gyland Jr., Lorenzo L. Parks and Edward R. Smith.

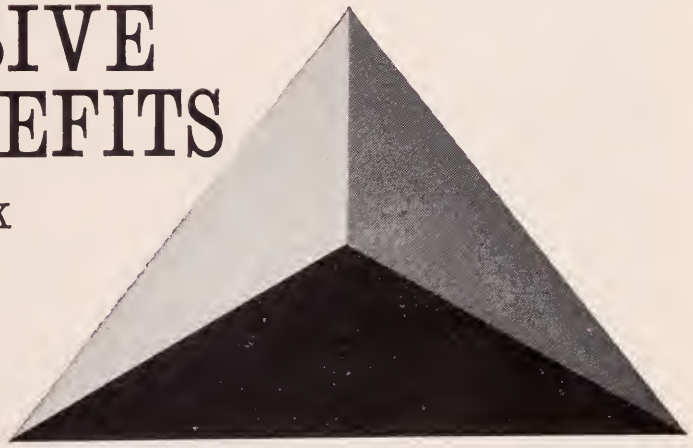
The final report of the campaign released by the Committee states that a card sent to all members of the Society inquiring whether participation could be counted upon resulted in 204 affirmative replies. Permission was granted by 144 physicians allowing the Society office to refer patients by telephone.

To promote the campaign, television and radio releases were prepared by the Department of Health Education of the State Board of Health

(Continued on page 70)

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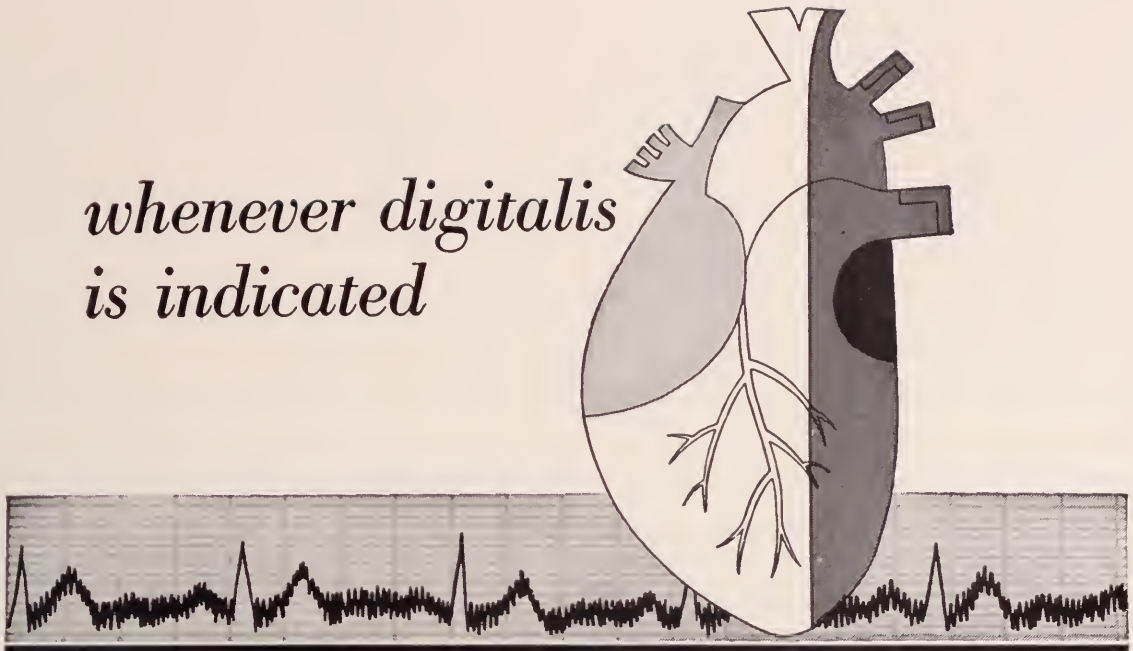
Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

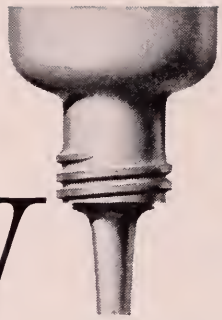
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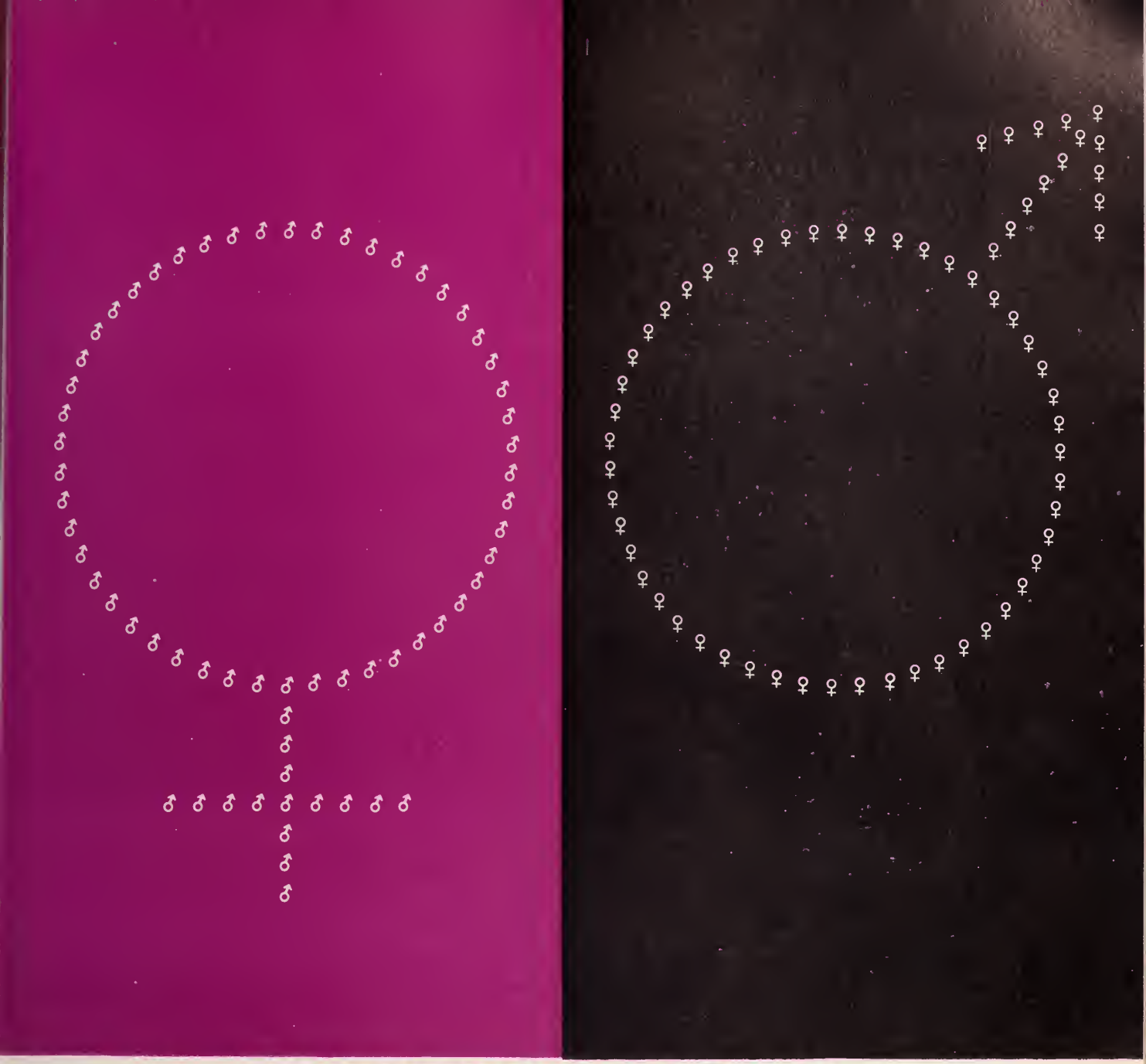
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Marinell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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CONVENTION PRESS

218 WEST CHURCH ST.
JACKSONVILLE, FLORIDA

(Continued from page 64)

and distributed to all stations in the area. In addition, slides were prepared for the two cooperating television stations. Mrs. John T. Stage, a member of the Society's Woman's Auxiliary, prepared an original drawing of a man in the acute stage of tetanus which was effectively used on more than 200,000 pieces of promotional material. Approximately 130,000 leaflets were mailed with electrical bills during the two month period, and about 70,000 more were distributed by physicians in their monthly statements, by members of the Duval County Pharmaceutical Association and the Safety Council. Approximately 1,200 posters were distributed by the members of the Woman's Auxiliary. Each physician's office received a poster together with brief instruction sheets for the use of doctors and nurses giving tetanus toxoid.

Charlotte

The Charlotte County Medical Society has paid 100 per cent of its state dues for 1960.

DeSoto-Hardee-Glades

Dr. James O. Ferguson of Sarasota was guest speaker at the March meeting of the DeSoto-Hardee-Glades County Medical Society held at the Arcadia General Hospital in Arcadia. Dr. Ferguson's subject was hiatus hernia.

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1960.

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1960.

Lake

Dr. W. Ansell Derrick of Orlando was principal speaker at the March meeting of the Lake County Medical Society held at the Elks Club in Leesburg. Dr. Derrick discussed the techniques, procedures and evaluation of bone marrow biopsies.

Pasco-Hernando-Citrus

The Pasco-Hernando-Citrus County Medical Society has paid 100 per cent of its state dues for 1960.

Polk

Professor Kenneth L. Black of the University of Florida, Gainesville, was guest speaker at the

In response to innumerable requests from dermatologists

Winthrop Laboratories now makes available

TRIQUIN®

FOR LUPUS ERYTHEMATOSUS AND LIGHT-SENSITIVITY ERUPTIONS

WHAT IT IS:

A combination of Atabrine® hydrochloride 25 mg., Aralen® phosphate 65 mg. and Plaquenil® sulfate 50 mg.

WHAT IT'S FOR:

Treatment of lupus erythematosus (chronic discoid type) and polymorphic light eruptions (light-sensitivity eruptions, solar urticaria or dermatitis).

HOW IT ACTS:

Each of the three components produces beneficial response in lupus erythematosus and light-sensitivity eruptions. Since the dose of each of the Triquin components is very low, overall toxicity is reduced and clinical tolerance improved. Furthermore, the three components appear to act synergistically.

HOW SUPPLIED:

Triquin tablets in bottles of 100, sold on prescription only.

Write for TRIQUIN booklet.



DOSAGE:

Lupus. Average initial adult dose, 1 or 2 tablets after meals and at bedtime. Dosage should be reduced gradually at two week intervals to 1 or 2 daily.

Light-Sensitivity Eruptions. Average initial adult dose, 1 tablet after breakfast and lunch. May be reduced after several weeks to maintenance dosage of 1 tablet daily.

Triquin, Atabrine (brand of quinacrine), Aralen (brand of chloroquine), and Plaquenil (brand of hydroxychloraquine), trademarks reg. U.S. Pat. Off.

Winthrop LABORATORIES New York 18, N. Y.

March meeting of the Polk County Medical Association held at Winter Haven. The title of Professor Black's address was "Estate Planning."

Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1960.

Volusia

Senator William Gautier was guest speaker at the March meeting of the Volusia County Medical Society held at New Smyrna Beach. The title of his address was "Legislative Problems Concerning the Medical Profession."

NEW MEMBERS

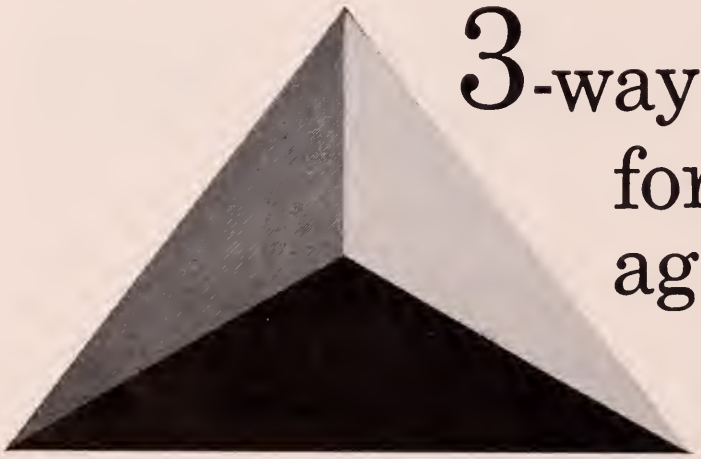
The following doctors have joined the State Association through their respective county medical societies.

Active

Camera, Antonio V., Lantana
de la Vega, Felix, Miami Shores
Forlaw, James R., Boynton Beach
Golubovic, Zivomer, Lake Worth
Guerin, Bernard K., Miami
Hirsch, Theodore, Hialeah
Hogg, Bruce M., Miami
Kelley, Virgil R., St. Petersburg
Manthey, Richard G., Boynton Beach
Millard, Max S., Miami
Morgan, Morton B., Miami Beach
Neill, James M., St. Petersburg
Newman, Abe L., North Miami
Newman, Raymond B., Miami
Pasach, Arthur J., Tampa
Pessolano, Louis C., Miami Springs
Robarge, Ignace, West Hollywood
Rosen, Robert R. Miami Beach
Saphire, Enoch J., North Miami Beach
Silverberg, Morris N., Miami Beach
Slosek, Edward F., Tallahassee
Spanjers, Arnold J., Winter Haven
Storey, Ben C., Titusville
Stuart, Jack F., Coral Gables
Van Eldik, Dick L., Lake Worth
Valin, Thomas J., West Palm Beach
White, William P., Melbourne

Associate

Adlerberg, Howard M., Miami Beach
Anderson, Harris R., Miami



3-way support for the aging patient...

ASSISTS PROTEIN UPTAKE
IMPROVES MENTAL OUTLOOK
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Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Folic Acid 0.4 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

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Beekman, Franklin, Pompano Beach
Bradshaw, Virgil M., Tampa
Cooper, Floyd C. III., Orlando
Crowell, David L., North Miami Beach
Curtin, Victor T., Miami
Dominguez, Jose R., West Palm Beach
Erickson, George M., Miami
Fagan, Lewis, Miami
Feinerman, Burton, Miami Beach
Gargano, Fredie P., Miami
Gibson, Clyde E., Bartow
Gibson, Thomas A., Bartow
Hillman, Charles C., Miami
Holland, Charles P., Palm Beach
Kaplan, A. N. Jr., Miami
Kyler, Stephen L., West Palm Beach
McCarthy, John A., Fort Lauderdale
Nayfield, Ruth K., Winter Haven
Norton, John A., Homestead
O'Leary, Richard G., Winter Haven
Pacheco, Ferdie, Miami
Piergeorge, Andrew R., Miami
Rowe, David L., Belle Glade
Sarmiento, Augusto, Miami
Sciscent, Verdi I., Fort Lauderdale
Slonim, Ralph J. Jr., Miami
Swords, J. Kenneth, Coral Gables
Weiss, Malcolm H., Miami Beach
Zbar, Marcus J., Fort Lauderdale

BIRTHS AND DEATHS

Births

Dr. and Mrs. Joseph Allison of North Miami Beach announce the birth of a son, James William, on March 1, 1960.

Dr. and Mrs. James J. Hutson of Miami announce the birth of a son, Mark Woodward, on March 5, 1960.

Dr. and Mrs. Sam W. Denham of Jacksonville announce the birth of a daughter, Anne Morris, on February 27, 1960.

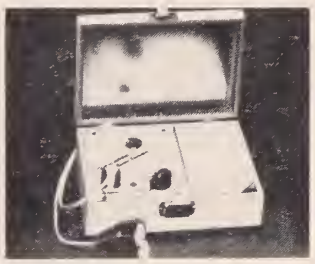
Deaths — Members

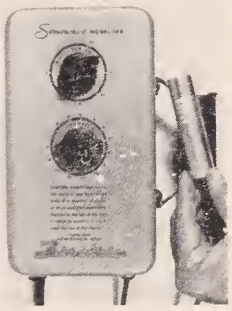
Collier, Miles A., Wauchula.....March 31, 1960
Dawson, Stephen A., St. Petersburg.....April 29, 1960
Girardin, Alphonse L. Jr., Fort Myers.....April 8, 1960
Greenhouse, Jerome M., Hollywood.....April 4, 1960
Gyland, Stephen P. Sr., Tampa.....April 15, 1960
McEuen, H. Bernard, Jacksonville.....April 15, 1960

Deaths — Other Doctors

Bigelow, Charles Tate, St. Petersburg.....March 9, 1960
Brown, Marshall S. Jr., Sarasota.....March 20, 1960
Eyster, John A. E., Fort Myers.....March 5, 1960
McClure, Earl W., St. Petersburg.....January 18, 1960
Verner, William W., Madeira Beach.....January 11, 1960
Olson, Carl T., St. Petersburg.....April 1, 1960

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RESEARCH UNITS


Activator Model Y-4


U. S. Model 108

Now ready for market following thorough clinical testing. For rehabilitation of face and small muscle groups, post surgical, accidents, palsies and metabolic changes with age, proven value of the newly developed Model Y-4 has been established. Likewise, the supreme value of Ultrasonic energy as a decongestant (well known) in painful and inflammatory conditions of facial and sinus areas, can now be accomplished by the specially designed U.S. Model 108. Both portable for physicians' office or can be carried in his bag. Both represent a new contribution to all branches of medicine and surgery. Manufactured by renowned Zeigler Electronics Company.

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New 4% Xylocaine® HCl applied topically to the larynx, pharynx, and trachea, gives fast, intense and profound anesthesia for endoscopic procedures. Whenever effective anesthesia of the mucosa of the eye, ear, nose and throat is required, topical Xylocaine HCl 4% offers all these advantages ▪ fast anesthetic action ▪ intense depth of anesthesia—not just surface analgesia ▪ effectiveness in small volumes—average 4 cc. ▪ patients experience no pain ▪ relatively nonirritating and nonsensitizing ▪ side effects are extremely rare. In ophthalmology, Xylocaine HCl 4% used both topically and by retrobulbar injection, provides fast, deep, and enduring anesthesia for a wide variety of major as well as minor surgical techniques. Xylocaine® HCl (brand of lidocaine*)

Administration and Dosage: For topical anesthesia, Xylocaine HCl 4% may be applied as a spray or with cotton applicators or packs, and by instillation into a cavity. The suggested volume ranges, for adults, from one to five cc. (40-200 mg.). For children, debilitated and aged patients, dosages should be proportionately reduced. Prior to removal of foreign bodies from the eye, examination of corneal lacerations, cauterization of corneal ulcers, and other surgical and diagnostic procedures, 2 to 3 drops of Xylocaine HCl 4% will usually produce adequate anesthesia. *How Supplied:* For Transtracheal and Retrobulbar Injection and Topical Application—Sterile aqueous solution dispensed in 5 cc. color-break ampules, packed 10 ampules to a carton. For Topical Use Only—Aqueous solution in 50 cc. screw cap bottles, individually cartoned.

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no irritating crystals[1] · uniform concentration in each drop[2]

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NEO-HYDELTRASOL®

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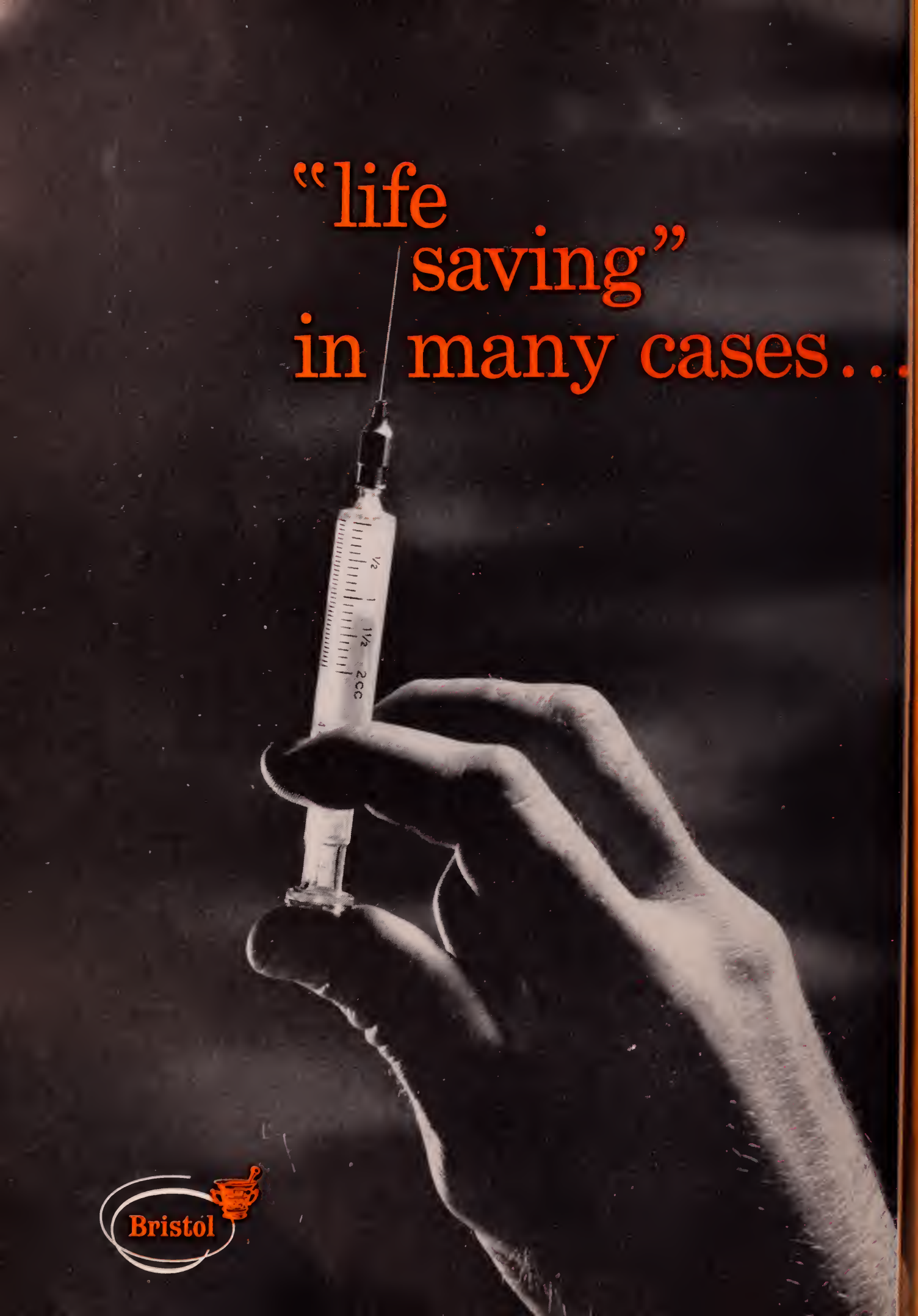
"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving . . ."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"...indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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WANTED: Radiologist seeking associate—congenial Orlando area. Limited volume, currently diagnosis only. Some hospital work. Florida license required. Write 69-322, P.O. Box 2411, Jacksonville, Fla.

WANTED: Two young associates for General Practice. One with training in anesthesia, the other in surgery, to be associated with General Practicioner with 28 bed hospital. Florida license required. Will guarantee suitable associates $1000 per month with partnership later. Write 69-352, P. O. Box 2411, Jacksonville, Fla.

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WANTED: Pediatrician for group practice in South Florida area. Florida license required. Please send credentials and other pertinent information to 69-381, P.O. Box 2411, Jacksonville, Fla.

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FOR SALE OR RENT: Air-conditioned office suite. Suburban Sarasota. Hospital three miles. Part of suite fitted as apartment for doctor until practice established. Reasonable. A. A. Edwards, 2030 Oak Terrace, Sarasota, Florida.

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RADIOLOGIST: Board certified in diagnosis and therapy with AEC licensure for isotopes, seeks Florida location. Have Florida license. Prefer hospital practice or partnership arrangement. Write 69-365, P. O. Box 2411, Jacksonville, Fla.

WANTED: Internist, Board qualified or Board certified, to be associated with two Internists in group. Minimum guaranteed salary of $12,000, plus percentage, for the first year, with eventual full partnership. Office located on east coast, between Palm Beach and Miami. Write 69-379, P. O. Box 2411, Jacksonville, Fla.

MEDICAL BUILDING—FORT LAUDERDALE—newly completed—successful—67% rented. Located on one of Ft. Lauderdale's major traffic arteries. Has definite need for General Practitioner, Internist, Surgeon, Dermatologist. For information and literature, call or write RoMark Bldg., 3521 West Broward Blvd. Reverse charges accepted. Phone LU 1-0900.

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OBITUARIES

Morris James Alexander

Dr. Morris James Alexander of Punta Gorda died at Charlotte Hospital in that city on Oct. 28, 1959. He had been in failing health since 1955 when he retired from practice. He was 69 years of age.

A native of Mississippi, Dr. Alexander was born at Austin. He received his preparatory schooling at Castle Heights School in Lebanon, Tenn., and his academic and early medical training at the University of Mississippi, where he was graduated in 1913. He then attended the Tulane University School of Medicine and was awarded the degree of Doctor of Medicine by that institution in 1915. He was a member of the Phi Kappa Psi social fraternity and Phi Rho Sigma medical fraternity.

Upon graduation, Dr. Alexander entered the general practice of medicine in Tunica, Miss., in association with his father, Dr. Morris J. Alex-

(Continued on page 96)

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Burdick EK-III Dual-Speed Electrocardiograph

The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

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Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design.
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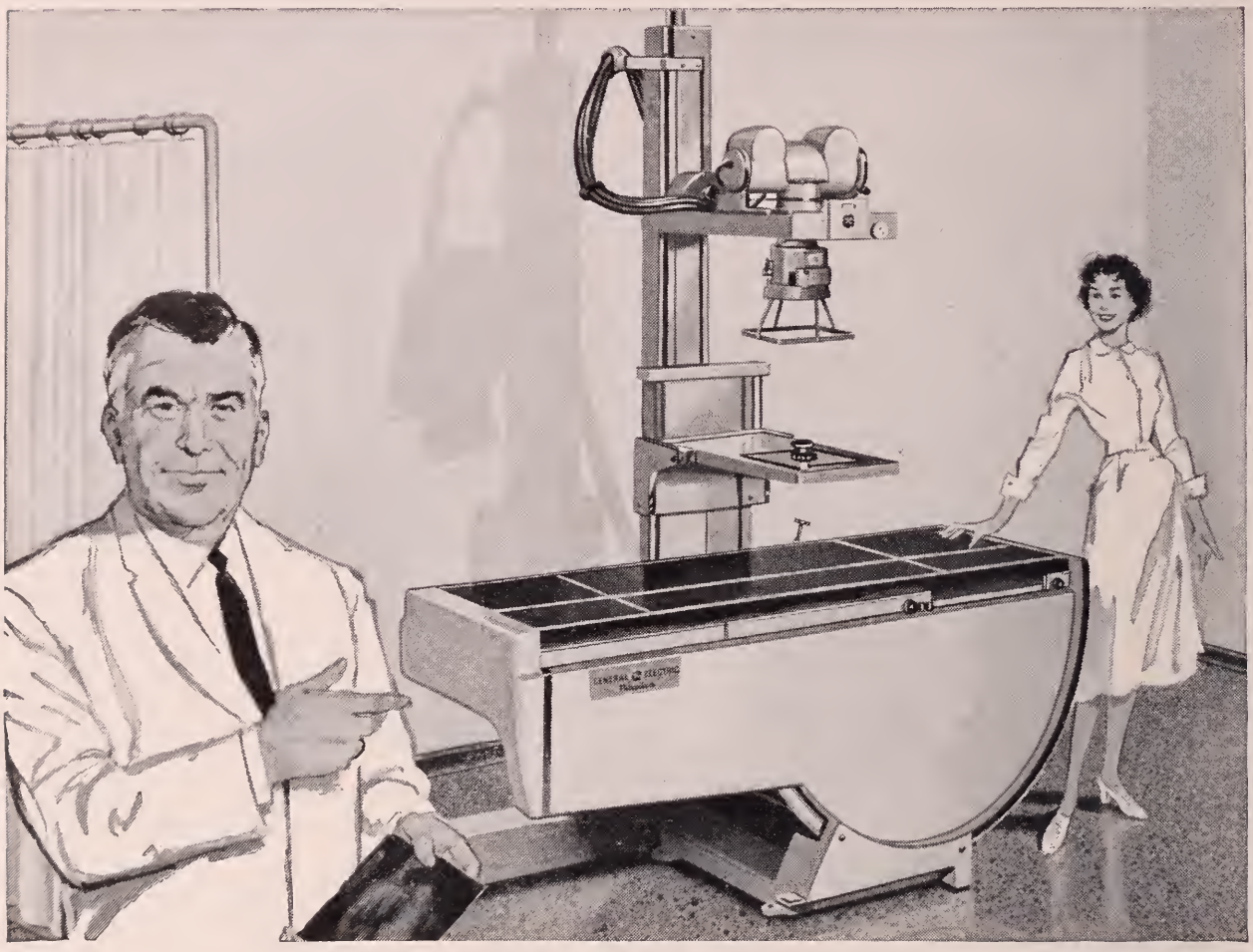
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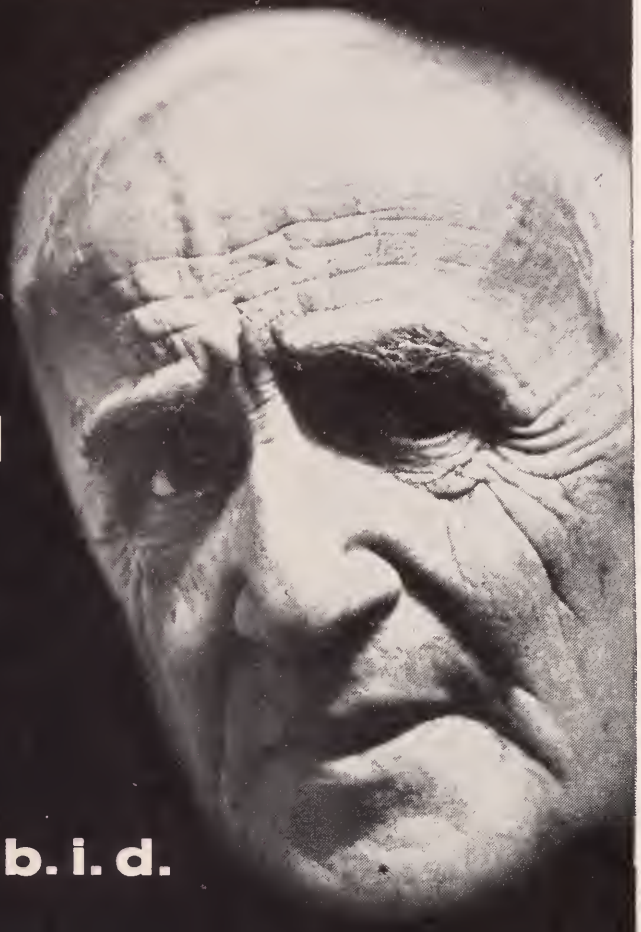
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- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

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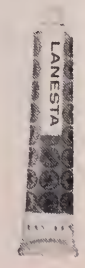
Because a swift-acting spermicide best meets the variables of spermatozoan activity.

Lanesta Gel, "...found to immobilize human spermatozoa in one-third to one-eighth the time required by five of the leading contraceptive products currently available . . ."* thus provides the *extra* margin of assurance in conception control. The accelerated action of Lanesta Gel — it kills sperm in minutes instead of hours — may well mean the difference between success and failure.

**Berberian, D. A., and Slighter, R. G.: J.A.M.A. 168:2257 (Dec. 27) 1958.*

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. Spermicidal action is greatly accelerated by the addition of 10% NaCl in ionic form. Ricinoleic acid facilitates the rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



new Lanesta® Gel

Supplied: Lanesta Exquiset . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio Distributed by GEORGE A. BREON & CO., New York 18, N. Y.

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When summertime chores bring on LOW BACK PAIN

Trancopal®

Brand of chlormezanone

relaxes skeletal muscle spasm—ends disability.



When any of a host of summer activities brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable. The spasm can be relaxed with Trancopal, and relief of pain and disability will follow promptly.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma, and postoperative muscle spasm. He noted that Trancopal produced satisfactory relief in 817 of 879 patients (excellent results in 268, good in 448 and fair in 101).

Gruenberg[3] prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series, Kearney[4] reported that Trancopal produced relief in 181 of 193 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Kearney[4] found "... that Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April. 1960.

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lmitic, stearic and myristic glycerides (saturated)	25-30%
ytosterol (predominantly beta sitosterol)	0.3-0.5%
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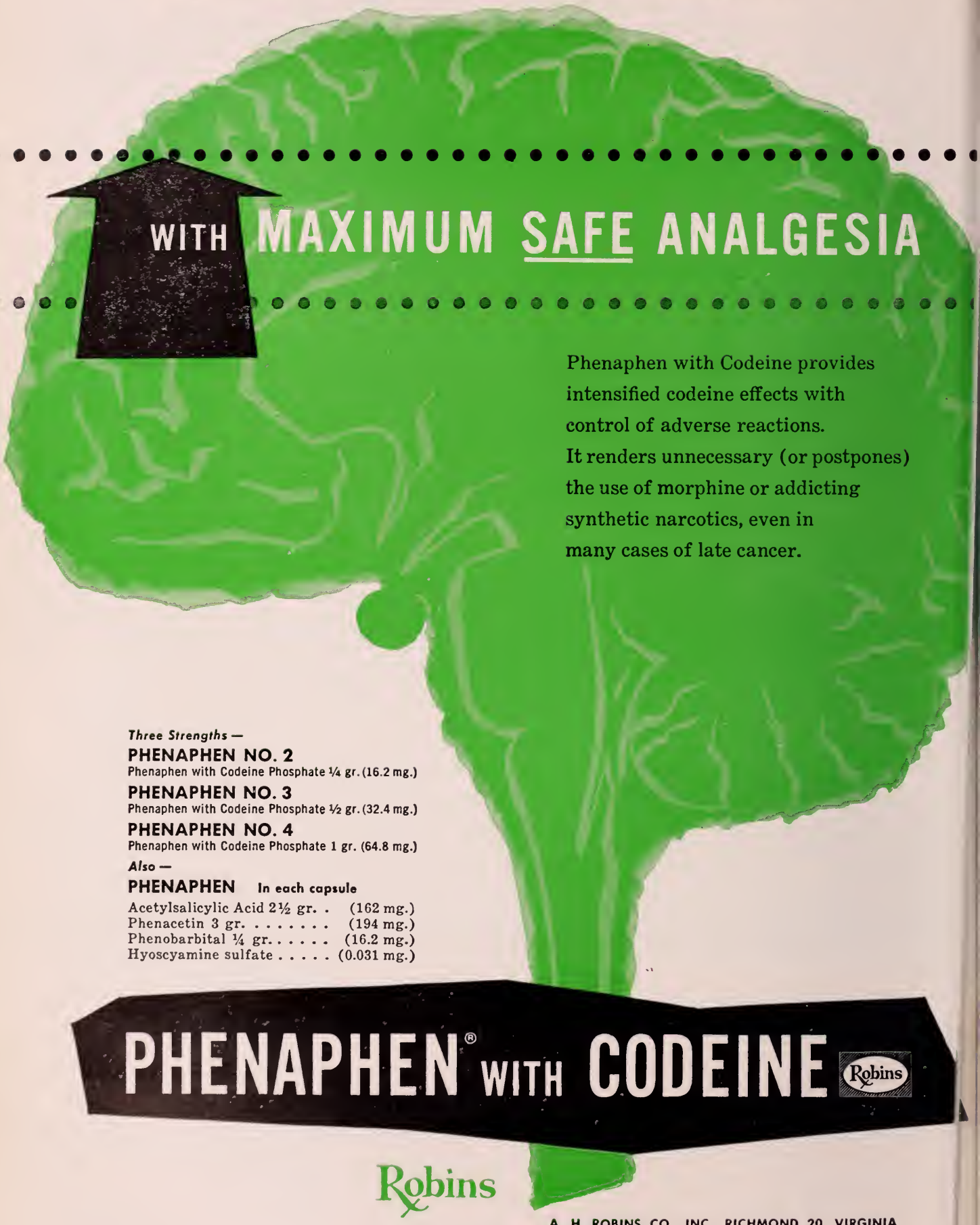
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The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

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now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

POTENT – **rapid relief in acute conditions**

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(Continued from page 79)

ander Sr., a former president of the Mississippi State Board of Health. After serving as a first lieutenant in the Army Medical Corps in World War I, he resumed his practice in Tunica for several years. From 1923 to 1933 he practiced in the coal mine district of Boone County, West Virginia. He then located in Florida, practicing first in Zolfo Springs. In 1935 he entered the general practice of medicine in Punta Gorda and continued in active practice there until November 1955.

Locally, Dr. Alexander was a member of the First Presbyterian Church, a past president of the Punta Gorda Kiwanis Club, one of the founders of Charlotte Hospital and a past president of the Charlotte Hospital Association, and a past commander of the D. N. McQueen American Legion Post. He had served as the first commander of the American Legion Post in Tunica after World War I. During World War II he was chairman of the Charlotte County selective service board.

In Mississippi and West Virginia Dr. Alexander was affiliated with his county and state medical societies. In Florida he was a member of Lee-Charlotte-Hendry County Medical Society and for 24 years had held membership in the Florida Medical Association. He was also a member of the American Medical Association and the Southern Medical Association.

Dr. Alexander is survived by his widow, Mrs. Maye Alexander, of Punta Gorda; a daughter, Mrs. D. D. Wasserman, of Great Falls, Mont.; and a grandson, Joe L. Thames, of Carrollton, Ga.

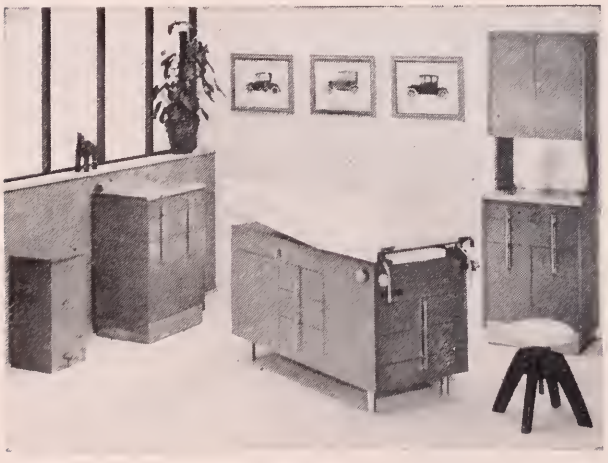
John Alexander Coleman

Dr. John Alexander Coleman died in his sleep at his home in Plant City on Oct. 19, 1959. He had been in failing health since suffering a heart attack some years ago. He was 63 years of age.

Born in Ohoope, Ga., on Aug. 30, 1896, Dr. Coleman in 1906 moved to Plant City with his parents, the late Mr. and Mrs. D. V. Coleman. In high school he was an outstanding athlete. He received his academic schooling at the University of Florida and his medical training at Tulane University School of Medicine.

Dr. Coleman returned to Plant City in 1925 to engage in the general practice of medicine and

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Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

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Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

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specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis In Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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was associated with the late Dr. J. C. Knight. Since that time he had served as family physician for many residents of the Plant City area. An outstanding citizen, he gave unstintingly of himself and his time to many civic activities through the years. He served as a member of the board of county school trustees for seven years and as chairman for two years. He then was a member of the county school board until he resigned because of ill health. Since 1929 he had been a surgeon for the Seaboard Air Line Railway. He helped organize and was president of the Plant City Music Association and also assisted in organizing the Elks Lodge and the Dads Club of Plant City. For 25 years he was the official physician for the Plant City Planters and helped secure Courier Field for the Plant City High School. He was a member of the First Baptist Church. In 1956 he was selected as Plant City's most outstanding citizen by the Junior Chamber of Commerce.

Dr. Coleman was a member of the Hillsborough County Medical Association and had held membership in the Florida Medical Association for more than a quarter of a century. He was also a member of the American Medical Association.

His widow, Mrs. Mary Dabney Coleman of Plant City, met accidental death some three weeks later. Other survivors include a daughter, Mrs. Elton Forehand Jr., of Edenton, N. C.; a son, John A. Coleman Jr., a senior at Tulane University School of Medicine in New Orleans; three sisters, Mrs. Bettie C. Cassels, of Plant City, Mrs. Paul D. Barns, of Miami, and Mrs. Robert T. Carleton, of Orlando; a brother, Arthur W. Coleman, of Plant City; and two grandchildren.

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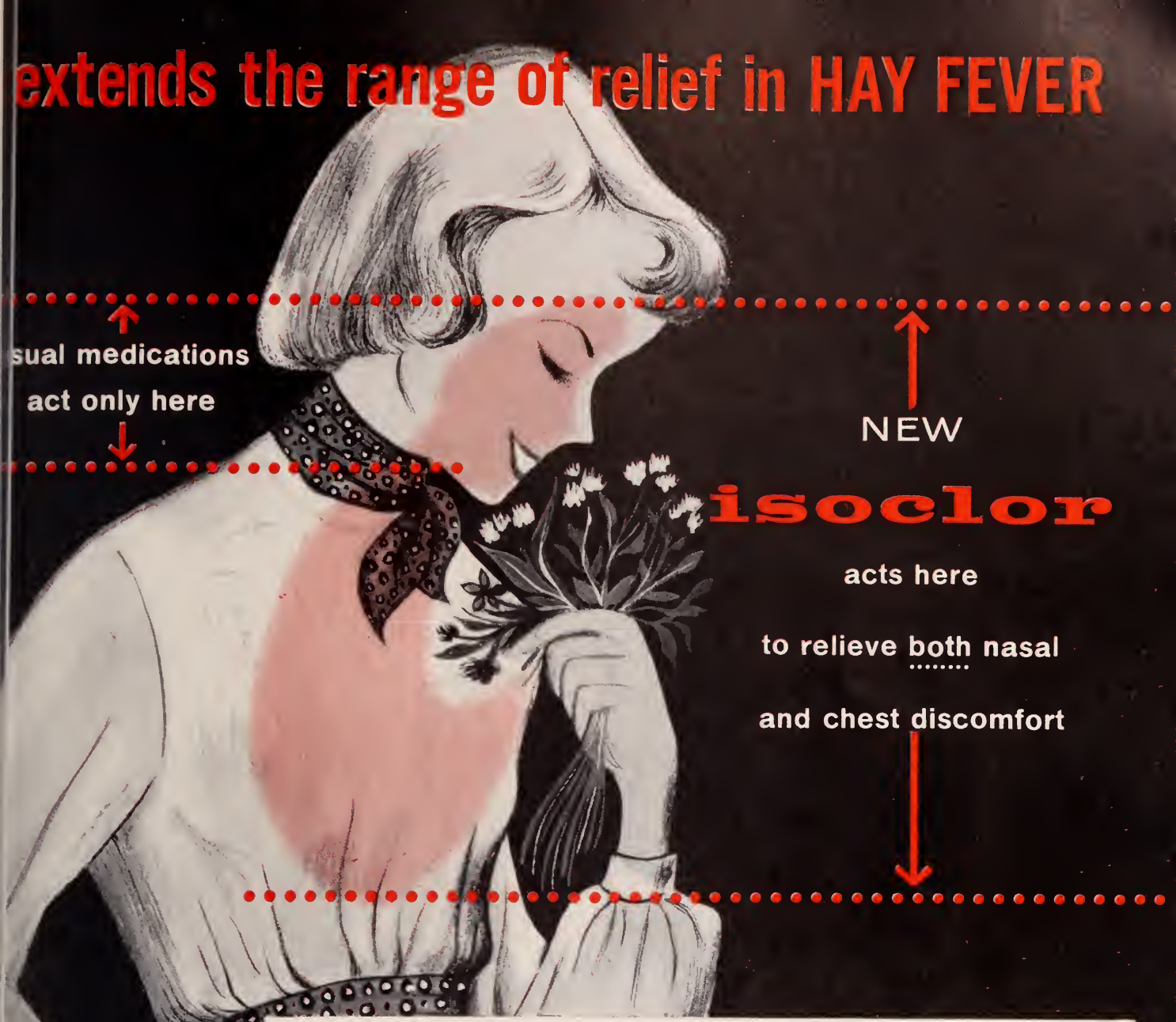
Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D., D.Sc. Ed. 7. Pp. 1462. Illus. 428. Price, $16.50. Philadelphia, W. B. Saunders Company, 1959.

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(Continued on page 106)

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Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

COMBINES the nasal and bronchial decongestant action of d-isoephedrine with the histamine blocking action of chlorpheniramine.

RELIEVES the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—let s the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

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COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate	4 mg.	2 mg.
d-Isoephedrine HCl	25 mg.	12.5 mg.

DOSE: Tablets: One tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d.; Adults: 2 tsp. t.i.d.

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REFERENCES: **1.** Gifford, R. W., Jr., *In* Hypertension, ed. by J. H. Moyer, Saunders, Philadelphia, 1959, p. 561. **2.** Moyer, J. H.: *Ibid.* p. 299. **3.** Brodie, B. B.: *In* Hypertension, Vol. VII, Proceedings Council for High Blood Pressure Research, Am. Heart Assn., ed. by F. R. Skelton, 1959, p. 82. **4.** Wilkins, R. W.: Ann. Int. Med. 50:1, 1959. **5.** Freis, E. D.: *In* Hypertension, ed. by Moyer, *op. cit.*, p. 123. **6.** Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. **7.** Fuchs, M., and Mallin, S. R.: Int. Red. Med. 172:438, 1959.

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For the "multi-system disease"[2] HYPERTENSION...
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Hydroflumethiazide • Reserpine • Protoveratrine A

A multi-system disease such as essential hypertension often requires a multi-therapeutic approach for satisfactory control. SALUTENSIN combines in balanced proportions three clinically proven antihypertensives. These components act through three different physiologic mechanisms to offer greater therapeutic benefits while minimizing the risk of side effects sometimes observed in patients on single drug therapy at maximally effective doses. The components in each SALUTENSIN Tablet:

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Protoveratrine A—"a potent hypotensive drug"[4] which is "well tolerated" in combination with rauwolfia;[4] a centrally mediated vasorelaxant that produces "the most physiologic, hemodynamic reversal of hypertension"[5]....0.2 mg.

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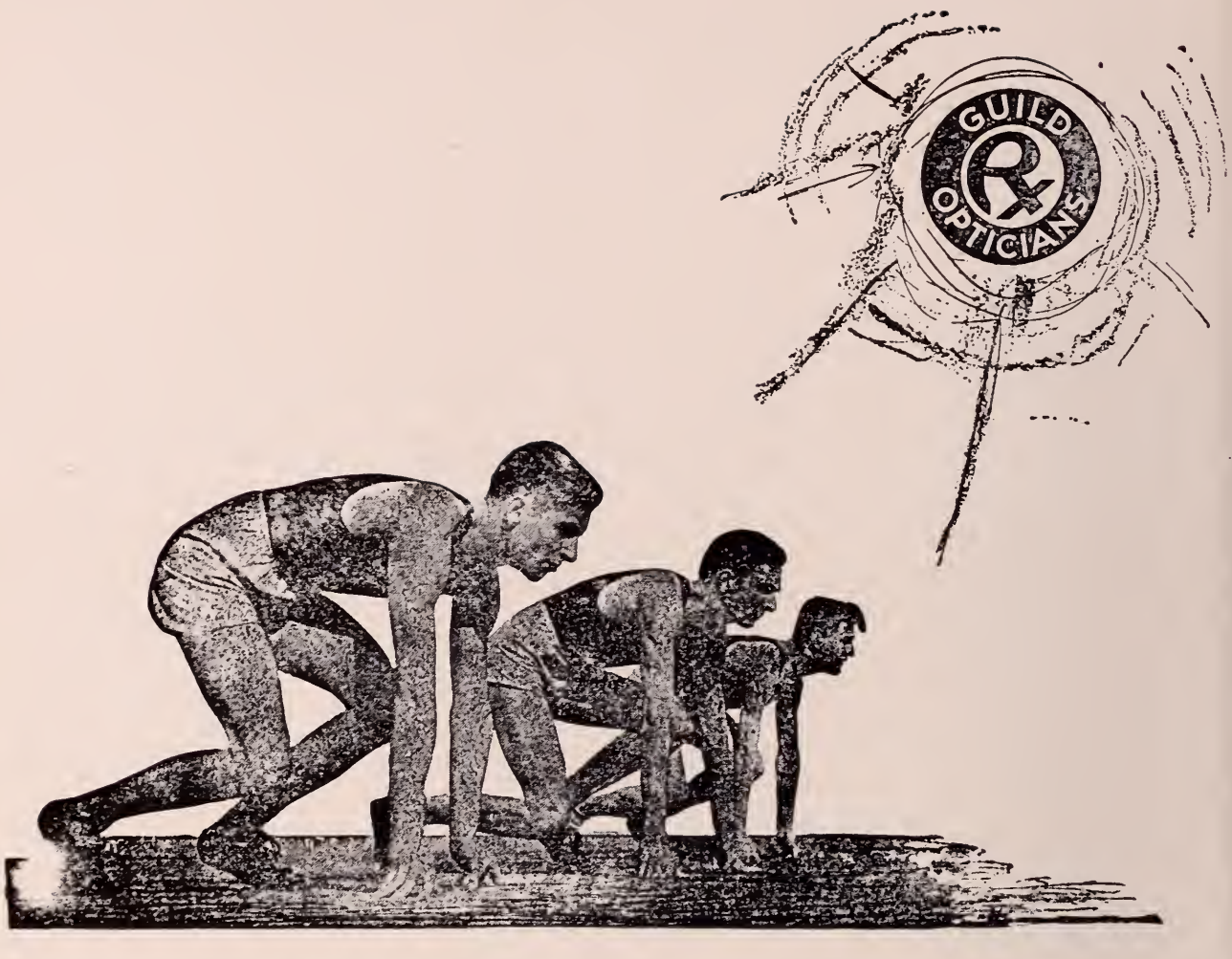
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The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

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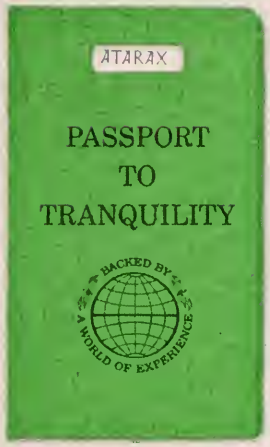
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Hearing. *A Handbook for Laymen.* By Norton Canfield, M.D. Pp. 214. Price, $3.50. Garden City, N. Y., Doubleday & Company, Inc., 1959.

This first volume in the new Layman's Handbook Series on disease and abnormal health conditions is an authoritative, sympathetic book offering new hope to the nearly 17 million Americans suffering from some form of impaired hearing. The distinguished author, who is Associate Clinical Professor of Otolaryngology at Yale University School of Medicine and President of the Audiology Foundation, has made this book more than a bible for the hard-of-hearing for it has a message also to doctors, nurses, teachers, fathers and mothers, employers, in fact, everyone who is directly or indirectly affected by a hearing handicap. The first of its kind, the book takes up, in nontechnical, easily understandable language, every aspect of impaired hearing—its causes, types, and treatment, as well as the psychologic and economic aspects of this important problem.

Childbearing Before and After Thirty-Five. By Adrien Bleyer, M.D. Pp. 119. Price, $2.95. New York, Vantage Press, 1958.

In this statistical study of the favored—and the less favored—years for human procreation, the author, a specialist in clinical pediatrics, sees a trend which has led him to conclude that the best years for maternity are those from 18 to 30. He arrived at his conclusions as a result of extensive study of the relationship of defectiveness in the child to the age of the mother at the time of his birth He contends that the chance that a mother under 30 will bear a defective child is relatively small, but that in women over 30 the percentage of defective children rapidly increases as the mother grows older. While his basic data have primary reference to incidence of Mongoloid imbeciles and dwarfs, he also deals with prematurity, miscarriage, stillbirth, neonatal death, twins, and oversize babies in relation to maternal age, and the effects on prospective mothers of high blood pressure, diabetes, and fibroid tumors.

That the Patient May Know. *An Atlas for Use by the Physician in Explaining to the Patient.* By Harry F. Dowling, M.D., Sc.D., and Tom Jones, B.F.A., assisted by Virginia Samter. Pp. 139. Price, $7.50. Philadelphia, W. B. Saunders Company, 1959.

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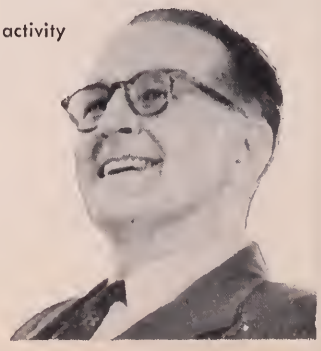
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The Modern Family Health Guide. Edited by Morris Fishbein, M.D. Pp. 1001. Price, $7.50. Garden City, New York, Doubleday & Company, Inc., 1959.

This new major home reference volume of authoritative medical advice and guidance by 27 noted doctors and specialists is presented in two parts. The first section is a comprehensive medical adviser consisting of 27 articles on health and disease, infant and child care, heart trouble, cancer, respiratory ailments, mental and nervous disturbances, problems of the later years, diet, and other medical subjects of concern to every family. The second section is an encyclopedia of medical terms containing hundreds of simplified definitions of the technical words and scientific expressions doctors use, plus concise descriptions of common illnesses and ailments. Alphabetical and cross-referenced so that related subjects in both sections may be referred to at a moment's notice, the book offers the layman valuable aid in understanding medical concepts and terminology. It enables the reader to be prepared in case of emergency, to be able to recognize danger signs before it is too late, and to know what to do until the doctor arrives. Written by today's leading medical authorities, the information and guidance presented are unavailable to the average person elsewhere.

The Ciba Collection of Medical Illustrations, Volume 3, Digestive System, Part I, Upper Digestive Tract. Prepared by Frank H. Netter, M.D. Edited by Ernst Oppenheimer, M.D. Pp. 206. Illus. 172. Price, $12.50. Commissioned and published by Ciba.

Just published is Part I of Volume 3 of The Ciba Collection of Medical Illustrations, "Upper Digestive Tract." When Ciba arranged with Dr. Netter to portray the major anatomy and pathology of all the systems comprising the human organism, it was planned to devote one volume of the Ciba Collection to each system. The interest shown in the digestive tract, however, was so great as to force an advance of the publication date by issuing the subject matter in three separate books. Part III, "Liver, Biliary Tract and Pancreas," came out about two years ago. The current book, Part I, covers the digestive tract from mouth through duodenum, while the final Part II will include the small and large bowel, rectum and anus. The new book contains 172 full-color plates with descriptive text by authorities in their fields both from this country and abroad. It is fully cross-referenced and features many bibliographic references for more detailed study. The material is arranged in seven sections: Anatomy of the Mouth and Pharynx, 29 plates; Anatomy of the Esophagus, 13 plates; Anatomy of the Stomach and Duodenum, 17 plates; Functional and Diagnostic Aspects of the Upper Digestive Tract, 29 plates; Diseases of the Mouth and Pharynx, 33 plates; Diseases of the Esophagus, 19 plates; and Diseases of the Stomach and Duodenum, 32 plates. This important contribution to medical education is available at cost and may be procured from the Publications Department, CIBA Pharmaceutical Products Inc., Summit, N. J.

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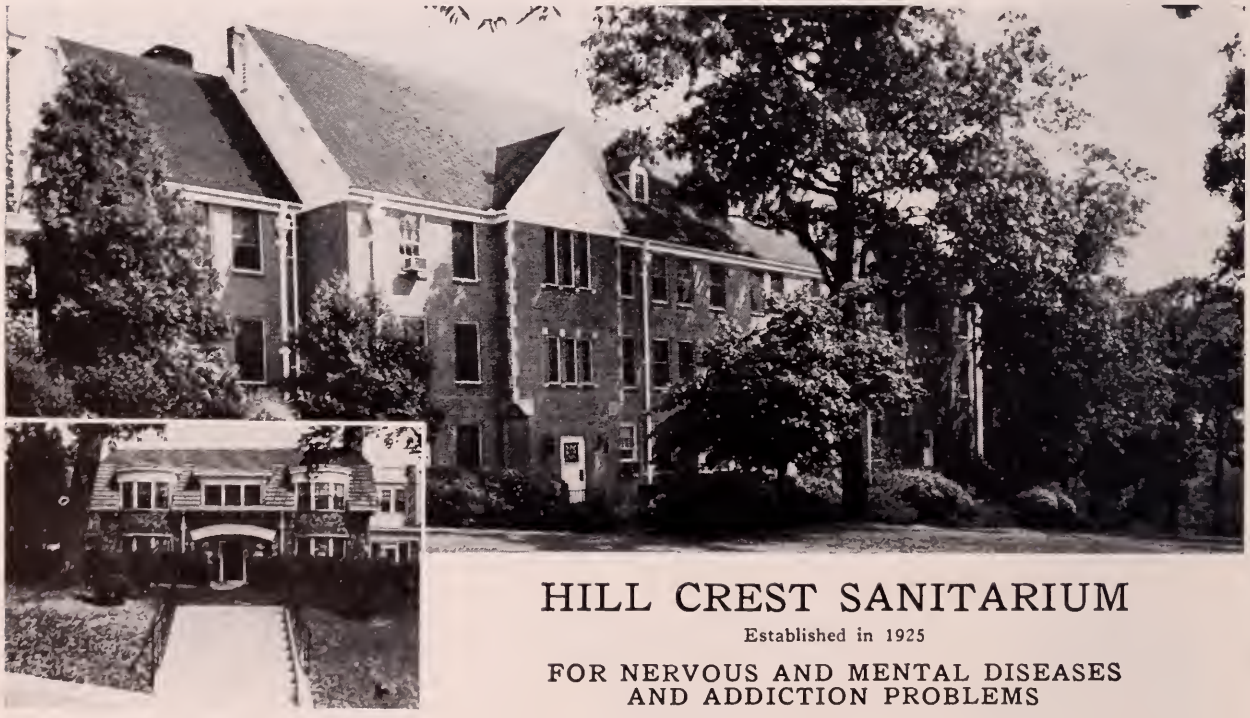
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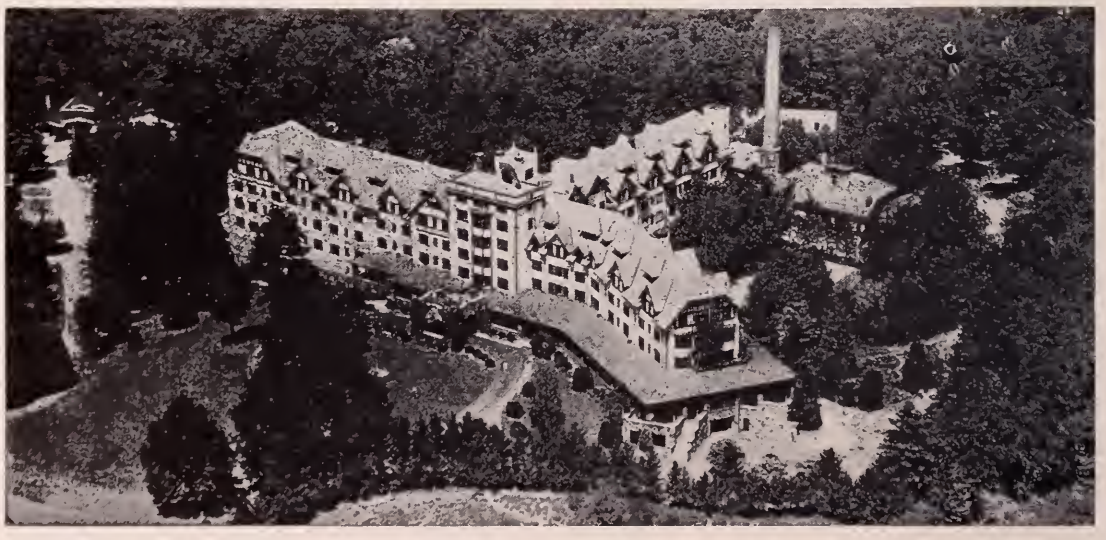
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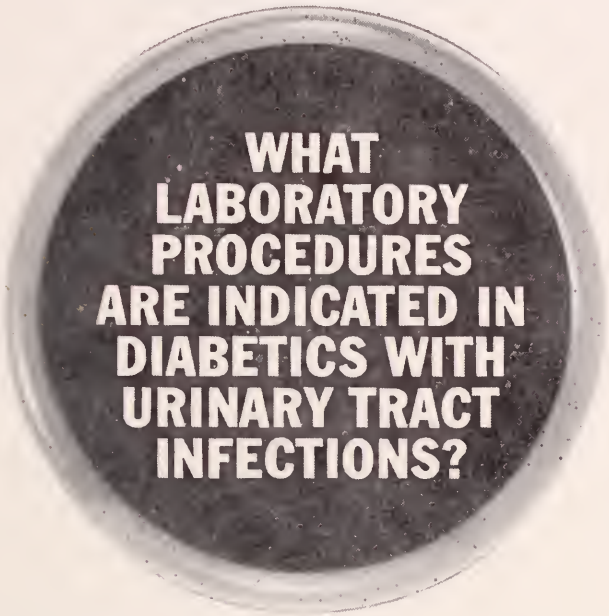
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	METING DATE	TOTAL MEMBERS Associate	Active
Alachua	Eugene H. Cummings, Gainesville	Richard E. Perry, Gainesville	2nd Tues.		78
* *Bradford, Gilchrist, Union*					
Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
Brevard	Cyrus E. Warden, Melbourne	Spencer C. Manrodt, Melbourne	1st Tues.	2	69
Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	30	265
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		6
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	74	1008
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		13
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	363
* *Clay*					
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	252
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	3	36
* *Sumter*					
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		38
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	8	75
Madison	Julian M. Durant, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	6
Manatee	Willett E. Wentzel, Bradenton	John A. Shively, Bradenton	2nd Tues.		40
Marion	Robert E. Thompson, Ocala	William C. Butscher, Ocala	3rd Tues.	1	33
* *Levy*					
Monroe	Walter R. McCook, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.		15
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	2	10
Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	24	229
* *Osceola*					
Palm Beach	Willard F. Ande, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	22	187
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	1	21
Pinellas	Chas. L. Farrington, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	13	311
Polk	Charles Larsen Jr.,Lakeland	Clarence L. Anderson, Lakeland	2nd Wed.	13	133
Putnam	Roy E. Campbell, Palatka	Norman B. Edgerton, Palatka	2nd Tues.		15
St. Johns	S. Raymond Cafaro, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.		19
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.		29
Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	3	91
Seminole	Edwin Epstein, Sanford	Robert J. Smith, Sanford	2nd Tues.	1	18
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	Irby H. Black, Live Oak	1st Sat.		9
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.		6
* *Dixie*					
Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	3	104
* *Flagler*					
Walton-Okaloosa-Santa Rosa	Joseph C. Wilson, Ft. Walton Beach	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	4	33
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	1	4
				217	3,745
			Grand Total		3,962

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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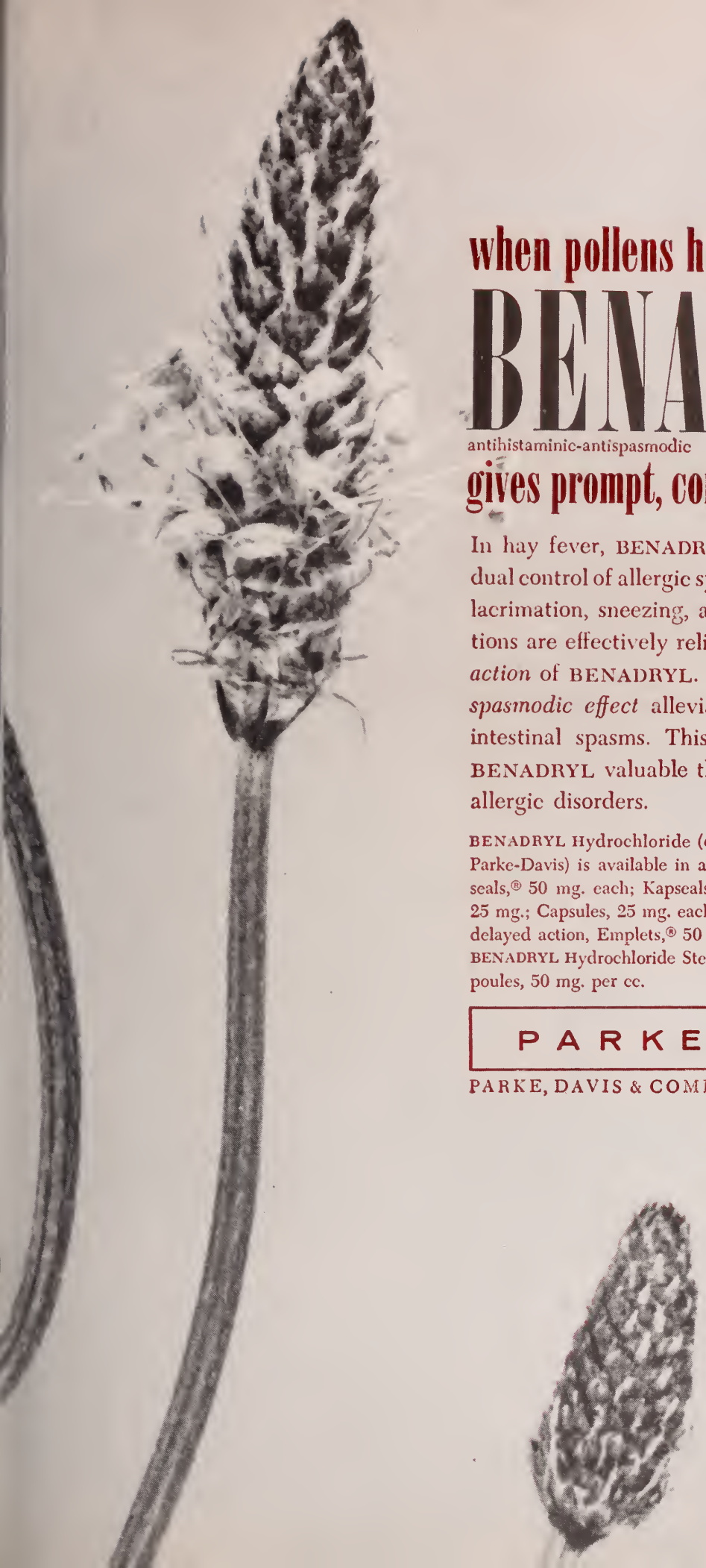


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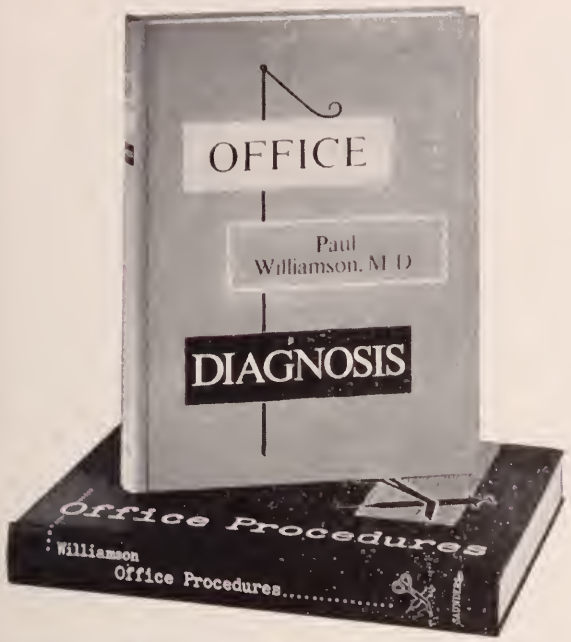
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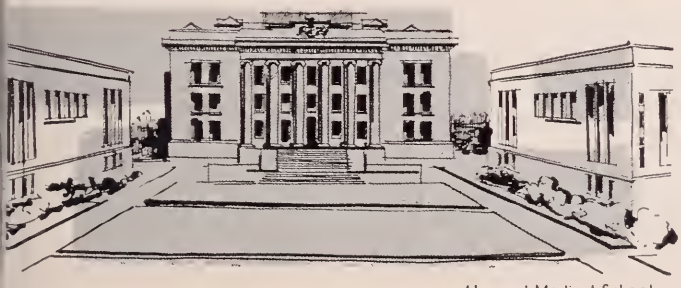
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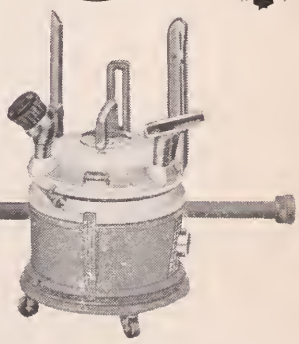
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Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.



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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

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Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

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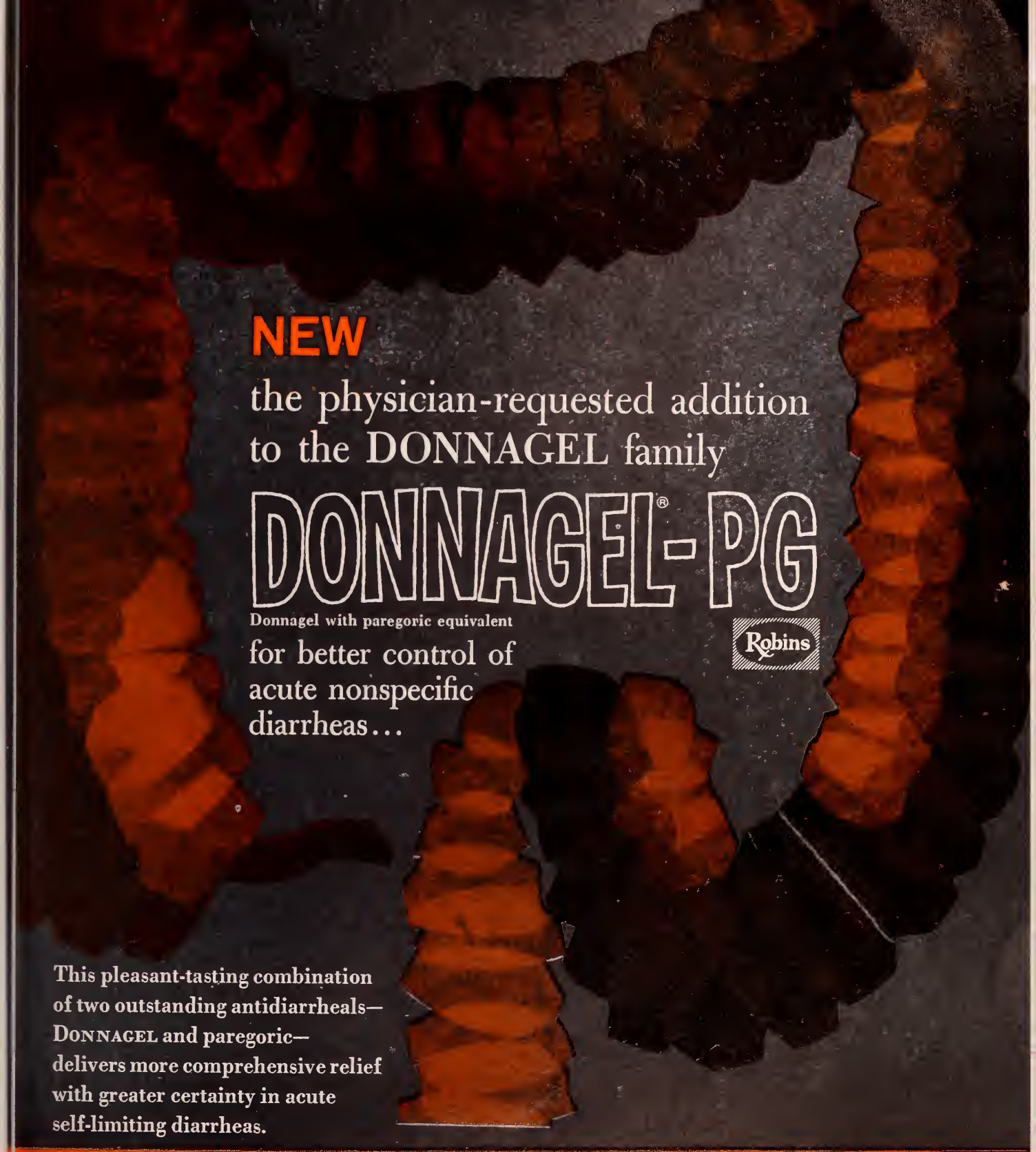
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*U.S. Pat. No. 2,864,745

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Problems Encountered in a Vascular Clinic

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AND
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JACKSONVILLE

In the last five years the old leg ulcer clinic of the Duval Medical Center has developed into the more dignified Vascular Clinic, and during that time its staff has grown from a single attending physician, one registered nurse and one orderly to three attending physicians, the same faithful registered nurse, two aides, two orderlies and any number of visiting student registered nurses, licensed practical nurses and house officers. Soon after the second attending physician began working in the clinic, this paper was conceived primarily in the form of kodachrome slides to present at a quarterly staff meeting for the purpose of revealing some of the bizarre and unusual clinical material seen in our clinic. As the months went by, photographs accumulated more rapidly than they could be coded and filed, and the problems of how to treat lesions taxed our diagnostic ability, forcing us to turn to vascular textbooks and review the literature. Over this period we have developed some definite ideas as to treatment and have accumulated many cases demonstrating combined peripheral vascular diseases that fail to respond to the usually recommended therapy. We have corroborated the opinions of some who have written about peripheral vascular diseases, but have also learned to doubt some statements that appeared in the literature.

The following remarks are limited to the diseases of the abdominal aorta and the lower extremities. Some conditions described and regularly seen in the clinic, such as vasospastic diseases, frequently affect the upper extremities as well. Oddly enough, the same faithful registered nurse assigned to this clinic for the past five years is affected with Raynaud's disease and has been under treatment for many, many years because of this condition. Her hands demonstrate the typical deformity of far advanced Raynaud's disease.

The most frequently seen lesion is found on the patient who originally incurred a minor trauma to the skin of the lower extremities which, through neglect, becomes infected. Cellulitis develops, followed by lymphangitis, phlebitis, then edema, dermatitis and ulceration. Eventually this condition subsides, either with or without treatment, only to recur in a grander state after a second traumatic insult. This sequence is repeated over and over until the patient has a lower extremity looking like that in figure 6b and 7a.

Diseases of the Arteries

Degenerative diseases of the arteries often produce narrowing, occlusion, or dilation and are divided into various categories depending upon the nature of the defect. When narrowing occurs, the rate of blood flow is not altered until the diameter of the vessel has been reduced 70 per cent. Symptoms, however, often appear long before the lumen has been so decreased in size.

Patients with obliterative vascular disease producing symptoms are candidates for peripheral

From the Vascular Clinic of the Duval Medical Center, Jacksonville, Fla.
Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

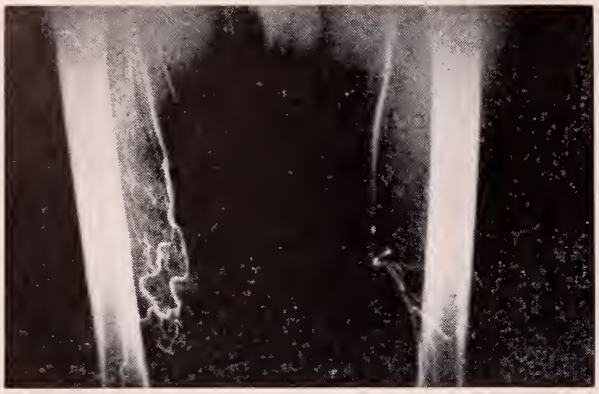


Fig. 1.—A rather typical picture seen in the clinic of bilateral adductor canal thrombosis, demonstrated by aortogram. This was treated with a by-pass graft on the right side and endarterectomy on the left.

vascular surgery and should have arteriographic or aortographic examinations.

Angiographic evidence of arteriosclerotic occlusive disease lags behind the pathologic changes present, and one should anticipate that the artery will be in a poorer condition than the roentgen evidence indicates. Furthermore, incapacitating symptoms may occur when radiologic changes are slight.

The earliest arteriographic evidence of atherosclerotic obliterative disease is blunting of the V of the arterial bifurcation. Filling defects also can be noted along the walls of diseased vessels, and these may be diffuse or segmental.

In 1950 Palma[1] made the observation, since noted often in routine arteriography, that many segmental obstructions appear to originate at the adductor canal (fig. 1). He concluded that "local trauma at this site produces atheromatous changes which start with an inflammatory reaction in the adductor canal as a periarteritis and proceeds through the wall to the intima." He was able to reproduce the lesion artificially by constructing a fascial canal in the leg of a dog. Complete or partial occlusion is similarly observed in the common iliac artery where it drops over the brim of the bony pelvis, is usually bilateral and, if neglected, may progress to the complete obstruction of the aorta as first described by Leriche.[2] A third but less common site for plaque formation, which can also be explained by trauma produced from the pulsating artery against a resisting adjacent structure, is in the common femoral artery as it emerges from the femoral canal. Here the pressure is on the posterior and medial aspects of the arterial wall.

Whether these segmental lesions are a separate pathologic entity or merely a variant of a conventional type of arteriosclerosis has not been determined. To some it thus appears that on the grounds of its anatomic and clinical features one is warranted in speaking of segmental arterial occlusion as a process distinct from generalized arteriosclerosis. More recent writers,[3, 4] however, do not agree that a segmental occlusion is a separate disease, but regard it as merely an early manifestation of arteriosclerosis, which in time will produce diffuse stenosis.

Arterial spasm plays some part in producing symptoms of many peripheral vascular diseases. In Raynaud's disease it is composed of intermittent constriction of small arteries or arterioles. It follows massive venous occlusion and will produce gangrene of the part unless it is relieved. It occurs in diabetes and in arteriosclerotic occlusive disease. We believe that the vasodilator drugs are worth while in treating arterial vasospasm and recommend their use. No one drug will improve symptoms in all the patients, but we have had best results with Arlidin. If that does not give satisfactory results, we do not hesitate to change to Roniacol or nicotinic acid. The patients who do not obtain relief of symptoms, we believe, probably do not have a vasospastic factor producing their distress.

Aortograms are obtained by inserting a No. 15 gauge needle[5] into the aorta at the level of the tenth thoracic vertebra. Femoral arteriography has been successful at the Duval Medical Center by performing a formal incision overlying the artery and then directly threading a polyethylene tube into the vessel before injection of the dye. Besides lessening trauma to the vessel with the chance of extravasation of dye and hematoma formation, it affords one an opportunity to inspect the condition of the vessel and to determine whether it would be suitable for attaching a graft at this point if there is demonstrated a need for one.

Probably aortography is unnecessary for the arteriosclerotic aneurysm if clinical signs and symptoms are obvious, but aortograms should be made if the aortic aneurysm is small or the patient is a poor operative risk. Most abdominal aneurysms arise below the renal arteries and can be palpated in the average patient.

Aneurysms are frequently amenable to the use of synthetic grafts. It is often stated that, roughly, one third to one half of all abdominal aneurysms produce death within one year of

discovery. If one believes this estimate, a considerable operative risk can then be assumed in order to rid the patient of this disease. On the contrary, we have seen patients with both abdominal and thoracic aneurysms go five years without surgery with the only complaint being occasional pains apparently from the enlarging aneurysm. Nevertheless, the mortality of 8 per cent in repairing nonruptured aneurysms as compared to 33 per cent mortality[5] during attempted repair of ruptured aneurysms makes us inclined to recommend excision and grafting in the good risk patient with reasonable long life expectancy.

Aneurysms of the peripheral arteries are less apt to threaten life, but frequently result in loss of limb when thrombosis or rupture occurs. The popliteal artery is particularly prone to aneurysmal degeneration (fig. 2), and ligation or endoaneurysmorrhaphy will cure the defect usually without loss of the limb. When possible, however, a graft should be considered. Factors to be considered when deciding whether a graft should be inserted in any given patient should include the severity of symptoms and their effect on the patient's social and economic situation, the severity and extent of arterial disease with particular reference to the circulation of the skin, and the likelihood of being able to carry out a successful arterial operation as demonstrated by the physical examination, the arteriographic evidence, and the general condition of the patient plus his ability to undergo the operation required.[6]

Pain at rest is a symptom of severe ischemia, a precursor of gangrene. Here, considerable risk should be assumed to avoid amputation. We have not attempted to graft distal to the popliteal artery; consequently, patients with palpable popliteal pulses have usually been excluded as candidates for grafting, regardless of the ischemia of the foot. If neither pedal nor popliteal pulses are palpable, it can be assumed that the origin of the obstruction lies proximal to the popliteal artery, and further investigation by arteriography should be undertaken. If the femoral pulsation is absent, the obstruction may lie high. In general, the most important factors to be demonstrated by arteriography are a healthy patent vessel above and an adequate outflow distal to the obstruction. Diabetes itself is not a contraindication to arterial grafting, but owing to the diffuse and often distal involvement of the vessels seen in diabetic patients, a smaller percentage of such patients will show symptoms of improved circulation following surgery.[7]



Fig. 2.—Arteriogram of a Negro woman who came to the clinic with a large, slowly growing tumor of the right popliteal area. The arteriogram revealed an aneurysm of the popliteal artery, which was later confirmed and treated with endoaneurysmorrhaphy, producing return of normal function to the extremity.

Recently, we have become enthusiastic about endarterectomy (fig. 3a and 3b), which has been used successfully in a number of patients who had multiple short segmental arterial occlusions.[8]

Lymphedema

Lymphedema is an accumulation of excessive lymph fluid in the subcutaneous tissues which may be caused by increased formation or by lack of absorption. The mechanism of formation of this fluid is dependent on one system of capillaries of the arterial tree. Excessive formation may result from increased intracapillary pressure, osmotic or hydrostatic, or from an increase in the permeability of the capillary walls. Decreased absorption may be the result of increased hydrostatic pressure in the veins or the lymphatics, or excessive osmotic pressure in these vessels. The walls of these vessels also may suffer in selective or general permeability. Lymph vessels either are modified veins or may arise initially from mes-

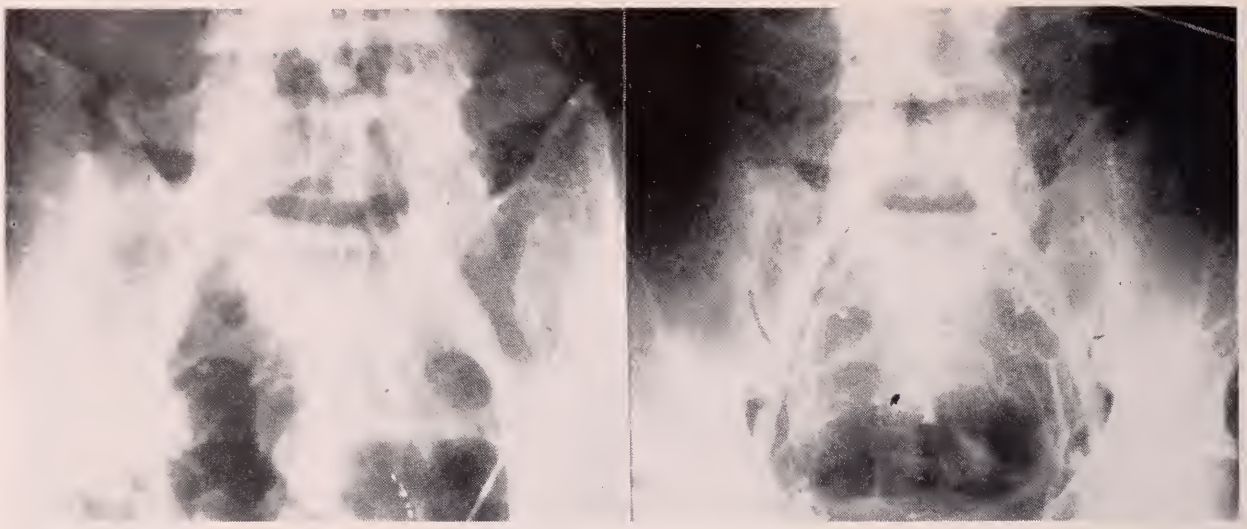


Fig. 3.—A. Preoperative aortogram of a 57 year old Negro man who had severe intermittent claudication of the left leg. There is a segmental occlusion of the common iliac vessel overlying the fifth lumbar vertebra that is outlined by the contrast medium. B. Twelve month postoperative aortogram following endarterectomy reveals the previously seen occlusion of the left common iliac vessel no longer present. The patient was able to walk 10 blocks without pain. There also was a segmental block on the right side in the external iliac artery which was not demonstrated on the aortogram, but was seen at surgery and also treated by endarterectomy.



Fig. 4.—A. Chronic lymphedema, etiology undetermined. The left leg reveals a scar on the inner aspect where a previous modified Kondoleon operation, followed by skin graft, has produced long-standing permanent relief. The right leg shows the edematous, shiny, tense skin, with small superficial ulcerations which temporarily responded satisfactorily only to bed rest. B. Right and left leg one year after a modified Kondoleon operation was performed on the right leg. The scar can barely be seen on the posterior medial aspect of the right leg, where skin flaps were undermined and the thickened subcutaneous tissue removed. A satisfactory two year convalescence has followed this procedure.

enchymal cells. They are closed vessels possessing an unbroken endothelial lining bathed on the outside by tissue fluid and normally well supplied with valves, while the larger lymphatic trunks have muscular walls. In the leg the lymph vessels are arranged in a superficial and a deep system. The communication between these two systems is through the popliteal and inguinal nodes. The deep lymph vessels in the muscle sheaths enter trunks that accompany the main femoral lymph vessels and drain into the large iliac nodes. It has been reported that even bone possesses some lymphatics. All the lymph vessels of the leg join at the groin and pass along the external and common iliac vessels through the iliac nodes. The lymph vessels hug the veins closely and may even be imbedded in the adventitia of their walls. Divided lymph vessels regenerate, and collateral circulation develops when these vessels are resected. Regeneration of lymph vessels is rapid, crossing a scar in approximately four days. The valves of these vessels serve as a most important accessory aid in the movement of lymph assisted by active and passive contraction of skeletal muscle. Lymph circulation is rapid, but varies greatly, and stasis producing incompetent valves abets lymphedema.

Lymphedema may result from many different conditions. True congenital lymphedema is usually used to describe edema beginning at birth, while that appearing near puberty is classified as lymphedema praecox, and when appearing later, lymphedema tarda. The underlying pathology appears to be maldevelopment of the lymphatics, either hypoplasia, aplasia or varicosed lymphatics.[9] Secondary lymphedema follows malignant invasion of the inguinal nodes, radical removal of the regional nodes, pressure from abdominal and inguinal tumors, and scar formation following roentgen and radium therapy. Medical causes such as cardiac failure, renal disease and hypoproteinemia must be kept in mind. Lymphedema may also be due to venous insufficiency or thrombosis, trichophytosis, systemic diseases, local tissue infection, or inflammation (fig 4a and 4b).

Lymphedema praecox (fig. 5) denotes an early development affecting mainly females between the ages of nine and 25. Often the onset is at puberty. The swelling occurs spontaneously and without any apparent cause. A puffiness is first noted about the foot. The swelling is more pronounced during long periods of activity at the time of menses and in warm weather. This extracellular fluid has a very high protein content, usually above 2.5 Gm. per hundred milliliters. In many cases only one extremity is involved. At first, rest in bed and elevation will usually remove the edema. In some cases the swelling remains limited to the foot and never appears to progress. In others, the edema advances up the leg slowly, and eventually the entire leg may be involved. Hair is lost. Cellulitis resembling an erysipeloid-like infection occurs frequently, and with each such insult, there are laid down additional layers of subcutaneous fibrosis. A heavy dull sensation is present constantly. The leg becomes wooden, and pitting is almost impossible to elicit. There is now little change in the leg after long periods of elevation, and bed rest no longer aids in the treatment of this condition. The skin becomes roughened and keratotic and shows wartlike excrescences. The leg now takes on the appearance of all that is implied by the word elephantiasis, or chronic inflammatory fibromatosis, an ambig-



Fig. 5.—Painless, diffuse swelling of the dorsum of the right foot and the lower one half of the right leg in a 12 year old Negro girl. The edema is nonpitting and only partially subsides on bed rest. It is controlled better with the use of an elastic stocking.

uous term which gives no clue as to the etiology of the swelling.

Lymphedema and venous edema cannot be differentiated clinically by the degree of pitting for both pit at first, then later become brawny with repeated attacks of infection. Before planning treatment one should decide whether the edema indicates an early transitory state or one in which an irreversible fibrosis has already developed. Congenital and juvenile types of lymphedema appear to vary merely in the degree of hypoplasia of the lymphatics. Injuries, infections, menses and pregnancies simply act to overload the already defective lymphatic circulation.

The treatment of lymphedema consists of mobilizing the fluid, preventing reaccumulation, removing segmental obstructions and removing irreversibly damaged fibrous tissue and skin. In the early stages postural drainage, with elevation, sedatives and analgesics, frequent active movements, adequate elastic compression of the edematous part, oral diuretics and restriction of sodium chloride have been our forms of therapy. We have tried corticoids unsuccessfully. In the treatment of chronic lymphedema we attempt to hospitalize the patient, maintain maximum elevation of the part, and request a low calory, low salt diet plus oral diuretics. All sources of infection, fungous and bacterial, are sought out, cultured and treated. Anemia, hypoproteinemia and hypometabolism are corrected. Chemotherapy and antibiotics are given to combat cellulitis. Some outpatients have been freed of their infection and kept infection-free on daily oral sulfonamides for as long as 12 months. Surgery is not advised in the milder cases in which elastic compression can keep the edema under control.

Only when the lymphedema is no longer controllable and the brawny edema with leathery thickened skin begins to appear (fig. 6a), producing disability or endangering the limb (fig. 6b) do we recommend surgical therapy. Surgical treatment has consisted essentially of removal of the fibrotic, lymphedematous inflamed subcutaneous tissue from the involved parts. We call this a modified Kondoleon operative procedure. It is based on the premise that lymphedema is suprafascial and there is no lymphedema in the subfascial muscle compartments. In the postphlebitic lymphedemas, or in long-standing cases in which the skin has become severely damaged, we have used split thickness free skin grafts (fig. 6c). In the early congenital types, in which the skin is healthy and not involved, we have attempted to preserve it as a full thickness flap. Elevation of the extremity should continue for approximately two weeks; thereafter, ambulation, with the extremity protected by two thicknesses of elastic bandage, may be begun.

Diseases of the Veins

Varicose veins are of two types, primary, which develop spontaneously, and secondary, which develop as the result of some obstruction, such as a pelvic neoplasm, the gravid uterus, scar tissue, arterial aneurysms, fractures, ascites and constrictive pericarditis.[4] The true cause of varicose veins is unknown, but the most generally accepted concept is that they develop because of an hereditary weakness in the structure of the walls of the veins themselves. Because of this weakness the veins are unable to withstand the relative increases of pressure that result from orthostatic pressure or increased abdominal pressure, or increases in pressure from continuous lifting, coughing or straining. In support of the former theory is the well recognized tendency of varicose veins to be familial. In support of the great influence of orthostatism is the fact that varicose veins are noted rarely in the arms or upper part of the trunk and are not seen in quadrupeds.

Obese persons appear to have greater tendency toward development of varicose veins. Relative increased pressure on the inferior vena cava and iliac veins from abdominal obesity may be important. Varicose veins also tend to develop with increasing age and emaciation. This characteristic is apparently a manifestation of loss of tone of the skin and tissue surrounding the veins and supporting them. Some believe that infections developing on the valves render them incompetent; consequently, varicose veins are one of the late complications of thrombophlebitis. A temporary or permanent obstruction at the iliofemoral vein increases the venous pressure during walking, producing considerable strain upon the superficial veins. This may be preceded by destruction of the valves of the iliofemoral vein. Then when the valves are destroyed, even though the lumen is restored, an unusual amount of strain on the superficial venous system is imposed. Rarely can a woman have more than two pregnancies without permanent varicosities if she has the hereditary tendency. Beside the mechan-



Fig. 6.—A. Lymphedema of several years' duration, secondary to thrombophlebitis of the deep venous system (1949), in a 30 year old Negro woman. B. Patient experienced repeated bouts of cellulitis, lymphangitis and chronic edema. Over a period of two years the leg gradually became so painful that she wished to have it removed (1951). C. Postoperative picture following a Kondoleon procedure (1954). This operative procedure consisted of stripping of the skin and thickened subcutaneous tissue down to and including the fascia of the underlying muscles. Split thickness grafts removed from the thighs were placed over the raw defects.

ical pressure exerted on the external and common iliac veins by the pregnant uterus, abdominal tension is increased by the enlarging uterus, and a marked increase in the volume of blood flowing from the hypogastric veins into the common iliac veins interferes with the blood flow from the lower extremities.

Essential pathologic changes in varicose veins are:

1. Dilatation or increase in the transverse diameter and circumference
2. Elongation and tortuosity
3. Loss of elasticity from increase in fibrous connective tissue
4. Variations in the thickness of the wall
5. Disappearance or atrophy of valves

When the valves in the greater saphenous vein are incompetent and the patient is in the erect position, the blood flow actually may be retrograde.

Blood flow and pressure are maintained in the veins of the extremities by the contraction of skeletal muscles, the action of the valves, the arterial pulsation, the negative pressure in the thorax with inspiration and the dilatation of the right side of the heart through diastole. Alterations in any of these factors may alter the venous blood pressure. The pressure also varies with the position of the extremity in relation to the heart. Pressure in the veins of the lower extremities is approximately 10 times greater when a normal person is standing erect than when he is recumbent, but venous pressure is lower during walking than during standing. Competency of veins varies from time to time, day to day, and even hour to hour. The competency of the valves of the saphenous vein is quite different when the patient arises in the morning after an eight hour sleep, as compared to their state after standing all day. This variation makes it difficult to determine the location of all incompetent communicating veins, unless examinations are repeated at various times during the day. This also explains why varicose veins during pregnancy will sometimes revert to normalcy post partum.

Since the complications of primary varicose veins are thrombophlebitis and chronic insufficiency with its various manifestations, treatment is of the utmost importance and can be divided into three general categories—conservative treatment, the use of sclerosing agents, and surgical procedures. Varicose veins appear to be an innocuous disease at first, but become less innocuous slowly, a condition for which conservative treatment is not entirely satisfactory, but prophylactic excision is certainly worth while.

Patients with a familial history of varicose veins should select occupations requiring a minimal amount of standing. Tight garters and constrictive clothing should be avoided. During antepartum examinations of pregnant women special attention should be paid to the condition of the veins of the legs. At the first indications of dilatation, a program should be devised permitting

only a minimal amount of standing, with frequent periods of rest with the legs elevated. Conservative treatment also should include avoidance of standing as much as possible, particularly standing without moving the muscles of the leg, elevation exercises, and recommendation of the use of various types of elastic bandages and stockings. When chronic insufficiency is not present, a light weight elastic stocking is satisfactorily used. Surgery is, if possible, reserved for the postpartum period.[10] We are not inclined to use sclerosing solutions as a basic treatment for varicosities, but only as an adjunct to stripping and to treat the rocket burst varix.

More and more there appears in the literature[11] the statement, with which we agree, that the only adequate treatment for varicose veins is saphenofemoral ligation, stripping, and ligation of all incompetent perforators. Treatment of varicose veins by ligation and stripping is based on the premise that the varicose vein is an embarrassment to the venous circulation and, therefore, its extirpation or destruction is desirable. As has already been mentioned, the incompetent great or small saphenous vein is a detriment to the venous circulation of the leg because the flow in it is retrograde. If this is pronounced enough, the deep veins are severely overloaded, and venous insufficiency is increased. The presence of deep chronic insufficiency with its various manifestations of edema, eczema, induration and ulceration is not a contraindication to treatment by stripping. Patients with veins of this type are best treated first by preliminary bed rest with the foot of the bed elevated and appropriate local treatment, rendering the leg free of edema and infection before surgery is contemplated.

Valvular incompetence of perforators is far more common in the leg than in the thigh. This is true of connections between the long and short saphenous system. Only by systematically palpating the visible or comparable tributaries can one detect the perforators and observing for retrograde flow can surmise that their valves are incompetent. Individual division of the incompetent perforators at or beneath the fascia fulfils requirement for cure of these varicosities and valvular incompetence when noted.

In cases of secondary varicose veins of the great or small saphenous system with incompetency of the great or small saphenous vein with or without incompetency of the perforating veins, the signs and symptoms may not be due entirely to the incompetency of the saphenous vein, but instead may be the result of the coexisting chronic venous insufficiency from incompetent valves in the deep femoral vein. In such cases the results of surgical treatment are incomplete, as far as the relief of signs and symptoms is concerned. Surgery is indicated on the basis that the incompetent saphenous vein is an additional burden to an already insufficient general venous circulation.

Ligation of the deep vein because of its incompetency is in general no longer practiced, and with this course we concur. Varicose veins of the vulva and the abdominal wall may develop as the result of previous obstruction to the iliofemoral vein. It is usually advisable to leave them alone, although if they are large and producing symptoms, surgical removal is desirable. Ascending thrombophlebitis and varicose veins of the great saphenous system with incompetency of the great saphenous vein are best treated by ligation of the saphenous vein primarily to stop the progress of the thrombosis. Some surgeons think there is no need to stage the stripping operation later, but do this at the time of ligation. The cause of recurrent varicose veins is an effective collateral hook-up which develops quickly between the tributaries from the saphenofemoral junction and the superficial veins in the thigh and leg after incomplete ligation. Varicose veins will always recur when incompetent perforator veins in the thigh, leg or foot remain. Sclerosing therapy is ineffective in treating perforators which are directly communicating with the deep veins. Removal of competent veins does not improve the function, and competent dilated collateral veins must be differentiated from incompetent superficial veins.

Chronic venous insufficiency results from:

1. Obstruction to one of the main veins of the extremity, particularly the iliofemoral, as the result of thrombophlebitis, neoplastic invasion, or external pressure.

2. Incompetency of valves of the iliofemoral vein, which may be primary, but more often is residual of an old iliofemoral thrombophlebitis without complete obstruction of the vein.

3. Varicose veins of the primary type, particularly those of long standing with incompetency of valves of one or both saphenous veins.

4. Extensive hemangiomas and anomalies of the venous system.

5. Congenital or acquired arteriovenous fistulas.

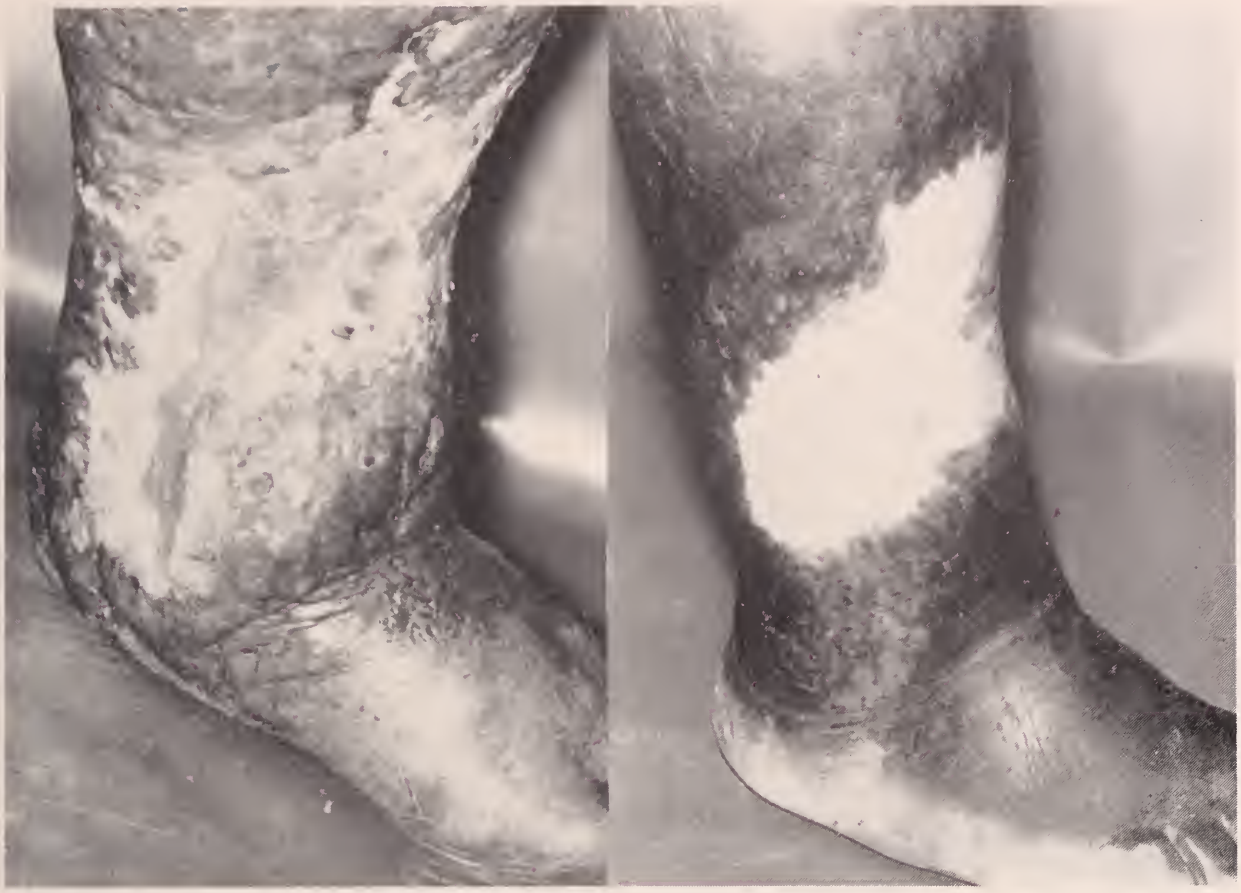


Fig. 7.—A. Chronic leg ulcer with thickened, indurated skin due to poor hygiene and lack of treatment. This ulcer has been present for about two years and followed deep thrombophlebitis. It was treated over a period of 18 months in the outpatient clinic with occlusive pressure dressings of the Unna boot type. B. The healed ulcer with absence of edema and return to near normal of the subcutaneous tissue and skin above and below the ulcer. The epithelium replacing the ulcer is not pigmented.

In both normal and abnormal states venous pressure is greater at the ankle, or much higher, when the patients are erect than when they are recumbent. In the presence of venous obstruction or incompetency of the valves, particularly of the iliofemoral vein, venous pressure has failed to drop during walking as when the veins are normal and the venous blood flow fails to increase. Increased venous pressures are transmitted back to venules and capillary loops during the acute stage of thrombophlebitis and malnutrition of these small vessels due to pressure, and low oxygen tension occurs as the result of stagnation of the blood. Complications of chronic venous insufficiency are frequently initiated by various types of trauma. The first manifestation of chronic venous insufficiency is usually edema, which at first develops during the latter part of the day and then completely disappears at night. It is largely subcutaneous, involving the region around the ankle and above the shoetop and is prevented in the foot by the constriction of the shoe.

Other signs develop only after orthostatic edema has been present for some time; then irregular areas of brown pigmentation due to deposited hemosiderin may appear. It is usually most noticeable just above the ankle. Deposits of melanin also may occur as the result of scratching or other trauma. Purpura and petechiae may be seen also. Dermatitis or eczema is a common manifestation of chronic venous insufficiency. It may be the chronic scaling type and may produce few subjective manifestations. In many cases itching is the first manifestation, and the eczema develops as the result of the persistent scratching, the so-called neurodermatitis. In some cases vesiculate eczema occurs. The longer the edema has been present, the more tendency there is for the development of subcutaneous fibrosis, and the less tendency there is for the edema to disappear when the patient is recumbent. A low grade inflammatory condition then develops around the ankle which much later becomes a hard brawny induration of the skin and

subcutaneous tissues. The skin overlying this induration may be dull red or brownish red and is usually warmer than the surrounding skin.

When indurated cellulitis has been present for some time, tissues may retract and shrink so that the skin is depressed. This cellulitis is painful and disabling and is often followed by ulcerations. The ulcers frequently develop at the site of minor contusions. In other instances they develop in areas of dermatitis, or chronic indurated cellulitis. After the ulcer has healed, there is a tendency for recurrence in the same area since the epithelial scar tissue is often atrophic; the ulcers become chronic and often secondarily infected (fig. 7a and 7b). They are aggravated by the use of topical antibiotics and ointments. Ulcers commonly occur in the region of the ankle just above or just below the malleolus, and especially the internal malleolus. Occasionally they heal rapidly, but usually tend to heal slowly and remain chronic if the patient stays ambulatory. The additional factor of infection often creates scar tissue and fibrosis which further impede the healing process. These ulcers due to venous insufficiency rarely develop on the upper portion of the leg and almost never on the thigh.

Patients with chronic venous insufficiency may complain of several different types of pain, although frequently they have no pain. A dull ache develops after the patient has been on his feet for a variable time. It is almost always worse when he stands still rather than when he walks. The pain usually disappears within five to 30 minutes after he becomes recumbent, with the leg elevated. Some patients with osteoarthritis of the knees, having venous insufficiency of one limb, usually have more pronounced articular changes in the limb with the venous insufficiency. Neuritis of the long saphenous nerve occasionally occurs, manifested by hyperesthesia in the region of the distribution of this nerve, and pain which may be paroxysmal and severe.

Chronic venous insufficiency must be distinguished from the edema of congestive heart failure and the edema of chronic nephritis. It must also be differentiated from chronic lymphedema, which is characterized by diffuse thickening and firmness of the skin, and does not subside on bed rest, if of any duration. Lymphedema is not associated with dilatation of superficial capillaries and veins, but when of long duration may be complicated by pigmentation, dermatitis and ulceration. Chronic venous insufficiency must be differentiated from arteriovenous fistulas and hemangiomas, and other anomalies which may produce venous obstruction. Neoplasms of the deeper structures of the leg, hematomas, abscesses and myositis from chronic venous insufficiency must be evaluated. These occur rarely.

Chronic venous insufficiency produces ulcers which must be differentiated from syphilitic ulcers occurring in the upper portion of the leg, often multiple and forming the pattern of a circle, or a segment of a circle. Syphilitic ulcers usually begin as nodules which ulcerate and then heal with a formation of thin atrophic scars. Arterial insufficiency and ischemia produce ulcers found most commonly on the toes and heels. These ulcers are usually more painful than the ulcers of venous insufficiency and have a pale base which is often partially or completely covered with gray or yellow debris or fragments of dead skin. The absence of pulsations of major arteries and postural color changes aid in diagnosis. Signs of congestion and chronic venous insufficiency are absent. Chronic ulcers of the leg may be self-induced, or may result from simple trauma, burns, excessive radiation, chronic ulcerative colitis, pyoderma, lymphoblastoma, Mediterranean and sickle cell anemia, fungus infection and other causes.

Patients with postphlebitic edema should avoid all vasoconstrictor influences, such as smoking and exposure to cold.[4] Elastic stockings and elastic bandages are very important in the treatment of postphlebitic sequelae. Ace bandages should be applied while the patient is in bed, before rising, and not removed until he retires.

Surrounding the actual ulcer one sees a darkened, discolored skin, associated with extensive induration, dryness, scaliness and eczema. The discoloration of the skin is the result of deposits from broken-down red cells. Because of disturbance to or complete loss of the normal sebaceous and sweat glands, the skin reveals an abnormal dryness and scaliness.

De Takats[4] observed: "Venous stasis is the first factor in the development of chronic leg ulcer. Associated with this is a progressive anoxemia and local acidosis, the result of stagnation of the metabolic processes in the skin and subcutaneous tissues, a decrease in arterial supply. One can see how slight trauma to tissues with the above alterations would serve as a mode of entrance to bacteria. Following the entrance of bacteria into an area of such low resistance the logical sequel would be cellulitis and lymphangitis,

or a lymphangitis with an associated phlebitis. Due to the lowered resistance, infection is difficult to combat. Progressive infection means further interference with lymph drainage, subsequent proliferation of scar and diminution of local blood supply. This produces a vicious cycle, progressing through stages of circulatory interference, lymph stasis, scar formation, and chronic ulceration." For treating the chronic leg ulcer we recommend total excision of the ulcer, the surrounding scar and discolored skin, as well as the deep fascia underlying the ulcerated area, following which a split thickness skin graft is applied. Prior to this procedure or at the same time a lumbar sympathectomy can be performed if there is an associated arterial disease.

Many of these ulcers can, if irreversible fibrosis has not developed around and beneath them, be cured by the application of occlusive bandages. The majority of our outpatients have ulcers of this type and can be rehabilitated by the weekly reapplication of an Unna boot.

In ulcers containing necrotic or fibrinous exudate, we have used Adolph's Meat Tenderizer, which the patient will tolerate better if it is unseasoned. A water soluble ointment containing streptokinase-streptodornase powder is helpful, but not as satisfactory as surgical excision or debridement. Putting the patient to bed, elevating the foot of the bed on 8 inch blocks, and applying warm saline compresses, unless contraindicated by wet dermatitis, will aid in clearing most infections. After cooling off the acute inflammatory condition, we recommend an Unna boot changed in the outpatient clinic every week or more, often depending upon the amount of drainage through the bandage. The boot is contraindicated if the patient is allergic to zinc oxide or has an acute dermatitis, and sometimes in hot weather. We prefer not to use local antibiotics because of the high percentage of sensitization although some of our patients have used Terramycin powder for long periods without any allergic reaction. The so-called stasis dermatitis may sometimes be due to autosensitization where the patient becomes sensitive to his own serum,[4] breaking out in a rash around the ulcer which eventually, unless properly treated, spreads over the entire leg. The action of the boot, as pointed out by Friedman, Henken and Frank,[12] is to work with the muscle pump which can squeeze tissue fluid more effectively against a rigid than against an elastic dressing. This muscle pump squeezing action is naturally limited when there is much fibrosis and if the main venous channel is blocked.

For this reason the patient with an acute deep venous obstruction will not tolerate exercise with a compression bandage. In large infected ulcers, it sometimes appears best to treat with surgery in two stages, first by excising the ulcer, then waiting for healthy granulation tissue to appear before applying a split thickness graft. During this first stage, the incompetent perforator veins and varicose saphenous system also can be excised. We prefer to use a split thickness graft varying in thickness from .011 to .013 inches.

Grafts will not survive for long unless all of the fibrotic ulcer base has been excised and the graft placed on healthy fascia, muscle or bone.[13] Generally speaking the patient with the split thickness graft implanted for recurrent postphlebitic ulceration needs to wear a bandage during the day for the remainder of his life. Occasionally, if there is a concommitant arterial insufficiency, we have performed lumber sympathectomy prior to grafting, following which it appears the results are more satisfactory and there is less often the chance of losing the graft.

Conclusion

Degenerative diseases of the arteries produce dilatation, narrowing and occlusion, and the therapy of these conditions lies within the realm of surgery.

Anyone with signs and symptoms of obliterative vascular disease should have a thorough physical examination to determine the patency of these vessels.

Roentgenologic investigation, including arteriography, should be a part of this examination.

The by-pass graft has been successful in our clinic in the treatment of the full-blown Leriche syndrome, and in the femoral-popliteal area when there is a long obstruction and a sufficient outflow tract is definitely established; however, we have been less successful with excision and end to end anastomosis with a synthetic graft.

Sympathectomy should not be performed with the hope of increased walking ability, but we believe lumbar sympathectomy should be performed more often prophylactically as a protection against trophic changes and ischemic neuritis before these conditions take place.

Recently we have had better results from thromboendarterectomy, which seems to offer the advantages of utilizing the patient's arterial tree for a patent channel without destroying the collateral supply. Short segmental occlusion in the common femoral and adductor canal can be safely treated this way. One disadvantage is that when the proper line of cleavage is established, it is difficult to know when to stop, for what appears on the arteriogram to be a segmental stenosis more often is a diffuse involvement.

A transverse arteriotomy below the occluded segment will yield the best line of cleavage and permit an accurate distal fixation of the loose intima to the arterial wall, preventing dissection, with possible occlusion and thrombosis.

We now consider excision and grafting as the only treatment for arterial aneurysms.

Definitive surgery for arteriosclerosis must be regarded as a palliative measure to overcome a threatened localized obstruction.

No surgical procedures should be considered for patients with marked cerebral, cardiac, renal or generalized vascular damage, or for those with a short life expectancy due to malignant disease.

Lymphedema is an accumulation of excessive lymph fluid in the subcutaneous tissue. It is classified in several categories. It may occur from obstruction or maldevelopment of the lymphatics. Treatment consists of elastic bandages, diuretics, and prednisolone. It may follow infection.

Single insults seldom lead to persistent lymphedema. Only after repeated minor trauma and its ensuing inflammation and cellulitis is there brought about a decompensation of lymphatic circulation.

At the onset of lymphedema a protein-rich interstitial fluid appears. This precipitates and forms a fibrinous exudate which acts as a scaffold for the proliferation of fibroblast, forming a hard, irreversible nonabsorbable lymphedema.

The edematous tissue itself goes through stages of progressive fibrosis. The increased tissue pressure causes arterial thickening and collapse of venules.

Whether or not the lymphedema becomes irreversible depends on the ability of the nodes to clear lymphatic pathways and sinusoids of fibrin and cellular debris.

Our treatment for chronic lymphedema has been a modified Kondoleon operation, resecting all of the subcutaneous tissue down to and including the deep fascia from the knee to the toes. If the skin has not already undergone an irreversible thickening and fibrosis, we prefer to preserve it to form a large full thickness skin flap which is resutured over the raw muscle.

The essential pathological changes of varicose veins are an increase in the transverse diameter, the circumference, and elongation plus tortuosity, with loss of elasticity, an increase in fibrous connective tissue, and disappearance or atrophy of the valves. Including patients who have congenital absence of valves and structural weakness, this disease is also seen in the older patients, those whose occupation requires constant long hours of standing, in multiparas and in patients with abdominal tumors or ascites.

Varicosities of the deep veins as a rule do not appear because of their surrounding musculofascial support.

Gravity produces a progressive increase in venous pressure, but this pressure is lowered during walking only to rise again when standing. Competent superficial veins noted on a patient when he arises in the morning may become temporarily incompetent after he has been standing all day.

Prolonged venous stasis in the erect or sitting position may produce edema but usually not from simple valvular incompetency of the superficial veins. Rather, persistent swelling appears only after incompetent communicating veins are present, when valves of the deep veins have become damaged, or when deep venous obstruction is present.

The edema so found then produces lymph stasis in which cutaneous and subcutaneous lymphatics become obstructed. It is thus noteworthy that an aggressive attack on early venous edema may well prevent the lymphedema with its high protein tissue fluid, subcutaneous scarring, increased pigmentation, and brawny indurated skin. Eventually from some simple trauma an ulcer may develop, frequently riding on an incompetent perforator vein.

In the clinic we see leg ulcers from syphilis, tuberculosis, and sickle cell disease in the Negro, but the vast majority are in such a condition that we can only guess as to their etiology.

The arteriosclerotic ulcer is usually more painful and on the heel or toes. Chronic leg ulcers are also seen with no obvious etiology other than trauma and neglect, or improper treatment.

When varicosities of the lower extremities are present, we believe that they should be removed. Removal should be carried out as prophylactic treatment if no ulcer exists, but if the varicosities are noted only when treatment for the ulcer is first requested, they can be removed during or after the ulcer has healed.

Saphenofemoral ligation and stripping of the long and short saphenous veins, as well as removal of the incompetent leg perforators, are essential for curing such varices when they exist.

The perforators are numerous, and when incompetent ones remain, they frequently are responsible for incomplete therapy.

Accessory perforator veins in the leg are not obliterated by the stripping of the long or short saphenous vein.

Summary

A few of the many chronic diseases encountered in the Vascular Clinic at Duval Medical Center and photographed over the last five years are presented as illustrations to a review of the literature on peripheral vascular diseases.

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The Office Diagnosis of Masked Depression

ROBERT G. STEELE, M.D.
SARASOTA

The title of this paper is a paraphrase from the treatise on psychopaths by Cleckely entitled the "Mask of Sanity." It is often noted that many psychiatric entities show diverse physical symptoms to lead the examining physician far afield. This certainly has been true in experience with the group of psychiatric afflictions known as depression.

In this paper it is planned to avoid as much as possible complex psychiatric and psychoanalytic terminology in order to make the contents more palatable for the general physician and internist. I trust my psychiatric colleagues in the audience will bear with me.

Masked depressions are rarely observed in people under 50 years of age. In the state of Florida we have a large segment of the total population in the older age group. Many of these people have uprooted themselves from a familiar way of life and are attempting to make the transition to an unfamiliar way of life down here. This change certainly puts a strain on the emotional structure of the older person which can bring out potential psychopathologic factors. Also, our fair state has been used as a prescription by many doctors in the North for various refractile physical conditions. One can certainly suspect that the many people with functional symptom complexes masking depression have often been treated with the suggestion that the patient change climate or take a long vacation in Florida. Also our older population is certainly numerically greater because of the simple fact that this is the mecca for retired persons. Thus it logically follows that we have a setup in Florida for an increased incidence of depression as compared to the rest of the country. I wish I could bring some valid statistics to prove this point, but must remain more or less anecdotal at this time. In reviewing serial cases of patients over 50 seen by me both in the office and hospital, I find that in this age group approximately 70 per cent of the patients have depression as a primary or major secondary diagnosis. The incidence of depression, for this state, may well be a worthy project for biostatisticians to work on.

Read before the Eighty-Fifth Annual Meeting of the Florida Medical Association, Bal Harbour, Miami Beach, May 5, 1959.

Diagnosis of Depression

Psychiatrists have always been concerned about the diagnosis of depression. Numerous articles have been written in various medical journals about the "missed" suicide, trends of depression, pathology of depression, et cetera. In many of these articles the point has been made that the general medical population is more apt to ignore, misdiagnose or underestimate depression than any other psychiatric entity. Depression is defined as a morbid sadness, dejection or melancholy to be differentiated from grief which is realistic and proportionate to what has been lost. Depression can vary from a mild feeling of unhappiness to a tremendous psychotic melancholy with overwhelming desire for self destruction. Psychiatrists qualify depression by various terms such as reactive depression, neurotic depression, involutional depression, and endogenous depression or depressive phase of manic-depressive psychosis. The type of depression I am referring to in this paper falls chiefly in the group termed involutional or endogenous depression..

It has been the experience of many psychiatrists, particularly in this state, that depressed persons often present themselves to their local physician complaining about some physical symptom. This is usually the chief complaint and over 80 per cent of the time is associated with the gastrointestinal tract. The complaint is usually couched in somewhat vague descriptive terms such as: "I have a funny feeling in my stomach," "I don't know what's wrong with me, but I have gas all the time," "food doesn't taste good to me, and I think I have an acid condition," and "I have a heavy feeling in my chest and stomach." These physical symptoms are what psychiatrists term depressive equivalents. This phrase merely means that they are physical symptoms of the emotional condition termed depression and carry the equivalent emotional significance as more clearcut psychogenic symptomatology.

When consulting the family physician the patient will dwell on these physical symptoms and add anorexia and insomnia to the list of complaints. As the doctor examines the patient,

he may note apprehension about what he, the doctor, comments upon. The patient may enjoin the physician to be candid in his statements with the implication that the worst is feared. The physician may get the feeling that the patient's verbalized specific complaints are minimal compared to the amount of suffering implied by the inflection in the patient's voice. The observation will occur to the doctor about as follows: "This poor old soul looks like he or she is really suffering, but all these patients talk about is a heavy stomach." This is what psychiatrists term "psychic suffering" for lack of a better phrase. What the patient is really complaining about is not the actual physical symptom but the depression, something that cannot be adequately expressed in words.

Common Findings In Depression

To make or rule out the diagnosis of depression a few simple observations may be helpful. Depression should be suspected in any patient over 50 years of age with cryptic complaints. It should also be suspected in anyone using Rauwolfia drugs. Let me say candidly that at times depression is a difficult entity to diagnose.

The first step is observation of the patient's motor behavior. In depression, psychomotor retardation is frequently present. The patient walks slowly and talks slowly; even thinking appears in a slowed-up fashion. In other cases of depression, agitation may be present with the patient literally pacing about the office in an uncontrollable fashion.

Next is observation of the patient's mood or affect. Look for the presence of drawn, apathetic facies, and statements about "not caring" anymore; look for statements from the spouse or family about personality changes. A simple indictator of affect is the patient's sense of humor. A gentle joke will seldom get any rise out of a depressed person. Depressed persons usually take little interest in their physical surroundings.

In depression, there is often a loss of interest in usual activities. The patient seldom volunteers this fact, but the family will usually notice it. A typical statement from the family might be: "Mother just isn't the same any more. A year ago she was busy with the woman's club, the church and gardening. Now she doesn't seem to care about any of these things."

In depression of a moderately severe degree an impairment of attention span is often present. This is best checked by inquiry into the patient's ability to concentrate. Statements such as "I can't follow a play on television" or "all I can read is the headlines and then my eyes blur" are examples of this mechanism.

Depression often shows itself in what we term morbid preoccupation. Statements such as "Doc, she reads the Bible all the time—she never did that before" are not to be ignored. The patient may volunteer that his or her thoughts are in morbid trends, but usually this state has to be inquired about directly. Also, it may be noted that the patient has many morbid fears about her actual physical symptoms. For example, the patient may fear that she has an incurable disease about which information is being withheld. Many times a person suffering from a depression will show a morbid preoccupation about the health of others. For example, if a casual friend has a carcinoma, the patient will become extremely concerned. Many times persons with a depression will dissolve into tears when asked about the frequency of crying spells. Some cry frequently; others will say, "I just wish I could cry, but the tears won't come." At times the depressed patient will try to hide this state and deny crying only to have it later brought out by the family.

A cardinal symptom of depression is sleep disturbance of a fairly typical type seldom seen in other afflictions. This is termed early morning insomnia. The typical depressed patient tends to go to bed earlier than usual, to wake up about four o'clock in the morning and at this time to feel most uncomfortable. The patient is generally miserable, the physical symptom worse and the morbid thought processes most distressing during these early morning hours. Compared to the anxious patient, the depressed patient seldom has trouble getting to sleep. The usual sedative, especially a barbiturate, has little effect on the early morning insomnia sleep pattern.

Another major symptom of depression is nonspecific malaise. This is expressed by complaints of continual tiredness and general weakness, and by statements such as "I used to be a ball of fire; now I am a lump of clay." In behavior it is expressed by retiring early, frequent naps and feelings of tiredness following casual social contacts. Since this symptom of nonspecific malaise occurs in so many functional and organic dis-

orders, it is advisable to put much emphasis on it in the specific diagnosis of depression.

Differential Diagnosis

Next I would like to discuss the physical symptoms of depression from a different orientation. The physician is always obliged to think initially of an organic process when confronted with a physical symptom. Admittedly, with the type of symptom I am referring to, this can force one at times to consideration of exotic disease entities such as pancreatic tumors, posterior gastric ulcers, abdominal crises of atypical Addison's disease and numerous others. This paper is not intended to advocate the abolition of careful physical examination, routine laboratory studies and routine roentgenologic studies when indicated. If, however, a masked depression is present, the failure to consider this entity may lead the physician on several medical wild goose chases. This strikes close to the heart of the paper. First, close attention to the patient's total personality, not just the symptom he presents, will help rule in or out the diagnosis of masked depression. Second, if the physical symptom masking depression has undue attention focused upon it, the symptom will tend to fix itself in the patient's psyche at both conscious and unconscious levels. It has been my experience with depression of the masked type that the more intense the physical work-up, including several cases with exploratory laparotomy, the more chronic and fixed the problem becomes with less hope for significant amelioration.

Next comes the knotty problem of differentiating the depression psychosomatic manifestations from those of other psychiatric categories such as pseudoneurotic schizophrenia, personality disorders, anxiety neurosis and others. Admittedly, at times this is difficult for even the most competent psychiatrist. I think the most honest advice I can give is to leave this differentiation to the psychiatrist whenever possible. To clarify this let me say that persons past middle life who have had previous emotional difficulties may well take on depression as a major feature of the emotional disorder. Bear in mind that the patient who has been labeled a neurotic for many years may well insidiously also turn into one with a fairly severe depression and respond nicely to appropriate treatment to many people's amazement.

Now I would like to give a few examples of masked depressions through abbreviated case histories. Let me state at the outset that there is no "typical" case of masked depression. It is helpful to look at the problem as a continuum ranging from frank depression without physical symptoms to one in which the physical symptoms mask almost completely the emotional problem. The first case illustrates the possible peradventure into which a depression may lead the well meaning physician through assiduous examination and treatment of physical symptoms. The second case shows how change of environment such as moving to Florida can contribute to the symptomatology. The third case shows the difficulties in treatment when the symptom becomes fixed.

Report of Cases

CASE 1.—A 58 year old white married housewife was initially admitted to the hospital by an internist for evaluation of abdominal pain, nausea, sore mouth and insomnia. She had enjoyed good health until about two years previously when she became concerned about her blood pressure. Some of her siblings were known to have hypertension and at that time had physical illnesses related to the hypertension. About two years before I saw her, she started seeing numerous doctors in her local area, first in one neighboring city and then in another with her varying complaints. She had innumerable blood pressure readings, several electrocardiograms were taken, and her gastrointestinal tract was x-rayed on several different occasions. During this period she also had received many different medications to relieve her various symptoms. None of these medications markedly altered her condition for any significant length of time. Shortly before her symptoms began, her husband had undergone a fairly extensive operation for carcinoma. His prognosis was good, but he had considerable physical impairment and had to give up his work.

The patient, until the past two years, had been most active in the local community. She was an active member of the local church, took a prominent role in many civic organizations and was considered to be one of the "friendliest" persons in town. When her physical symptoms began, she also underwent social withdrawal. She gave up all her civic activities, was loathe to leave the home and became aware that her symptoms all increased when she was out with company.

In my examination of the patient I found her to be apprehensive, making many purposeless movements and giving the superficial appearance of being happy. Aside from the physical complaints noticed previously, she mentioned her severe insomnia, which was worse in the early morning hours, and generalized malaise. When I asked her directly if she felt depressed, she dissolved into tears and went on to discuss her extreme religious preoccupation, morbid preoccupation with death and continual fear that she was not ever going to improve. At this time she also felt able to discuss the fact that her physical symptoms were quite a bit out of proportion to the degree that she was suffering.

It is noteworthy that in this patient, once we began discussing her emotional symptoms and general psychic state, the physical preoccupation diminished markedly. She went on to receive a series of electric shock treatments, and the condition improved greatly.

CASE 2.—A 63 year old white married man, whose presenting complaint was gas and constipation, had recently moved to Florida because of his wife's health. He had also

recently retired from a responsible position in a Northern city somewhat sooner than he had planned to, again because of his wife's health. The patient was seen initially by a general practitioner, and his trouble was believed to be a functional gastrointestinal disorder. He had a full work-up including complete roentgenologic studies of the gastrointestinal tract. No organic pathologic changes were found. Initially, a regimen designed to alleviate the functional disorder of the gastrointestinal tract was prescribed, but the therapeutic response was minimal.

When I first saw this man he showed the following: cancerophobia, early morning insomnia, social withdrawal and morbid, self-accusatory thought processes. His ancillary physical complaints were severe constipation, anorexia, a sense of abdominal distention described "like a sausage moving around inside of me" and constant fatigue. His wife added that he had taken to reading the Bible, a new departure, had become unrealistically penurious, and had started retiring extremely early in the evening. Also, the wife noted that his facial expression was like "a man in pain" whenever he had to venture out of their small apartment.

In further discussions with this patient I found that he had been, in reality, most unhappy about the move to Florida and had considerable chronic unexpressed hostility toward his wife, who was somewhat domineering. Furthermore, he had had a mild affair with one of his secretaries about a year before about which he felt especially guilty.

The patient responded fairly well to a short course of shock therapy and was followed in psychopathy afterwards, during which he verbalized a good deal of his hostility toward his wife. Since then their relationship has become much more realistic, and his physical symptoms have disappeared completely.

Case 3.—This case illustrates some of the treatment problems encountered in longstanding cases of masked depression in which considerable attention has been placed upon the physical symptom. A 72 year old white housewife entered the hospital with a chief complaint of persistent nausea. She had had abdominal complaints of various sorts for approximately the past six years. Five years ago she had been referred to a prominent Northern diagnostic center, where complete studies and a diagnosis of functional bowel disorder were made. At that time her complaints were of abdominal pain of a migratory nature. Subsequently she was treated by several physicians, both in Florida where she lived in the winter and in a Northern state. The course was one of increasing severity with sporadic ups and downs. About two months before I saw the patient, she underwent an exploratory laparotomy with lysis of a few small adhesions. No pathologic condition was found. Subsequent to the laparotomy the pain disappeared, but the symptom of nausea superseded it. This was severe and started approximately one day postoperatively. The symptom persisted to an incapacitating degree and proved refractory to most medications.

When I first saw the patient, I noted that she appeared depressed, but she steadfastly denied depression. She did admit to early morning insomnia and also to the fact that her physical symptoms were much worse at this time. The husband discussed the social withdrawal that she had shown steadily over the past two to four years.

The course in the hospital was a somewhat stormy one. She was sedated fairly heavily the first night and awoke the next morning in a symptom-free state. The following afternoon her husband visited her, and immediately the physical symptoms began and quickly reached an intolerable level so that I was contacted for emergent parenteral medication. She responded poorly to this treatment and slept poorly the following night in spite of the fact that she was receiving the same medication. Two days later, a course of electroshock therapy was instituted, and after the first treatment she changed her complaint from nausea back to abdominal pain. After the third treatment the abdominal symptoms had completely disappeared, but she was complaining of nonspecific malaise. Shortly thereafter, the patient was discharged from the hospital, and two days after discharge the symptom of nausea returned. She was given antidepressant medication, and a fairly firm management control was instituted. This ameliorated the situation somewhat, but two weeks later she was readmitted for another course of electroshock therapy. Following this the physical symptom disappeared, and when seen a month after hospitalization, she was free of physical symptoms, was leading a normal, outgoing life and according to her husband was better than she had been for the past seven years.

The psychiatric entity of depression is a difficult one to treat, particularly the group known as masked depressions. It has been my impression that the more fixed the physical symptom is, the more refractory the problem is to treatment.

We in psychiatry must frankly admit that the treatment of depression in this older age group is not entirely satisfactory. New drugs are constantly being put on the market specifically designed to have an antidepressant effect. I would estimate that during the past year approximately four such medications have come out. Drug companies are expending millions of dollars in research to find a satisfactory antidepressant medication. It is the consensus of most psychiatrists that no one drug exists today which is a wholly satisfactory antidepressant. It is hoped that in a few years we will have a drug which will significantly ameliorate depression so as to be considered useful without side effects that obviate its general acceptance. It is our experience in Sarasota that the most effective treatment in this type of depression is electroshock therapy. I believe this is the consensus of most psychiatrists, not withstanding a few dissenting reports to the contrary. In the older age group psychotherapy for this affliction has proved uniformly disappointing.

Concerning electroshock treatment, in my experience it has proved to be tolerated well even in the extremely aged and debilitated. I routinely use intravenous Pentothal Sodium and succinylcholine to alleviate the apprehension and obviate the possibility of fractures. I would like to state categorically that electroshock treatments have never been proved to produce permanent organic brain damage in spite of anecdotal statements to the contrary. In spite of the fact that depression may prove a difficult entity to treat even under adequate psychiatric management, the results can be gratifying.

Conclusion

This paper points out the relatively high incidence of depression in the older age groups, particularly in Florida. The physical symptomatology that is often seen masking depression is described. We in psychiatry believe this diagnosis

is liable to be missed in the family physician's office, especially if masked by a physical symptom. A plea is made for its consideration in the cryptic afflictions of anyone over 50 years of age.

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Discussion

Dr. John B. Liebler, Coral Gables: The symptoms of a masked depression described by Dr. Steele fall into three main spheres: autonomic nervous system imbalance, skeletal pain, and gastrointestinal complaints. The differential diagnosis of these symptoms includes preponderantly metabolic and endocrine disorders. All of the following organic conditions have been found responsible for depression plus the other nonspecific symptoms mentioned, and all are conditions which occur in elderly persons: hyperthyroidism and hypothyroidism, hyperparathyroidism and idiopathic hypoparathyroidism, simple malnutrition with minimal pellagra or sprue, bromism and iodism.

Idiopathic hypoparathyroidism, although thought of and often taught only in terms of tetany, has been found responsible for the now familiar symptoms of fatigue, weakness, neurotic behavior, palpitation and paresthesias which insidiously increase before the onset of frank tetany or convulsion. It has been reported in patients up to the age of 67.

The difficult task for the organically inclined diagnostician is that of analysis of the significance of frequently found and frequently symptomatic degenerative conditions of elderly persons in relationship to the presenting symptoms. As a specific example there is the elderly man with osteoarthritis of the back, diverticulosis and hiatal hernia with some prostatism, complaining of backache, vague abdominal distress and constipation, who may be secondarily emotionally upset by his physical symptoms. Dr. Steele is to be complimented for his emphasis upon the crux of diagnosis, which is observation of the patient as a whole and a separate interview with family or friends to elicit positive evidence of involutional melancholia.

Although the risk of iatrogenic fixation of the somatic equivalent of depression is well recognized and is to be avoided if possible, this risk can be minimized by an extremely confident, orderly and obviously thorough work-up of the patient. Three possible profits overbalance such a risk: First, confidence gained by thorough examination leads to ready acceptance of diagnosis and subsequent psychotherapy. Secondly, when organic causes are confidently excluded by the responsible physician, the psychogenic nature of the illness frequently becomes more apparent to the patient, perhaps "like the smile of the Cheshire cat," and is readily accepted. Of course the third gain is the diagnostician's delight when, after he has examined many hundreds of such patients, one of the exotic organic causes is disclosed and proved responsible for vague symptoms.

The experiences of those of us associated with the Geriatric Clinic of the University of Miami School of Medicine would indicate that many symptoms of a minor nature in elderly persons may reflect dependency needs. If these dependency needs are even partially met by an understanding staff, the need to repeat the symptom month in and month out to the physician may disappear even though the physical condition is unmodified. This has attracted our attention to the psychologic needs of the patient that exist "behind" the verbalized complaints.

Our experience with severe depressions, one of which unfortunately terminated with suicide, seemed to be associated with contemplation of major surgical procedures. Patients known to be disposed to depression, who because of the medical urgency surrounding the operations cannot be adequately prepared psychologically, must be closely watched.

Dr. John M. Caldwell, Miami: Dr. Steele has done a service by calling attention to the frequency of depression in the older age group. It should be emphasized perhaps that most people who are ill, or feel ill, are lonely, afraid, and have feelings that are easily interpreted as depression. Dr. Steele, however, has correctly directed attention to the concomitant physiologic changes that should be apparent before the diagnosis of a depression is made. The characteristic emotional reaction to stress in the older age group is that of depression. This is not strange when we think that the typical nuclear emotional conflict of that age group is, according to Erikson, ego integrity versus despair. By ego integrity is meant the acceptance of one's own life cycle as something that had to be. Too frequently we see in our mature citizens, unfulfilled goals, dissatisfaction with the past, a record of disappointment and frustration.

We might reflect too that mental health is dependent upon the satisfaction of current emotional needs. To maintain emotional homeostasis certain needs must be supplied from the environment. Maslow has listed a hierarchy of such needs: (1) basic physiologic needs such as food; (2) the need for safety, that is an organized, reliable, constant, familiar world; (3) love needs, that is, acceptance, belonging to and having a place in the group, giving and receiving affection; (4) esteem needs, that is, respect from others, prestige, appreciation, achievement, independence, freedom, and (5) self fulfillment needs, that is, the full use of one's own capacities.

In the treatment of persons suffering from depression environmental manipulation to secure fullfillment of emotional needs and psychotherapy often give satisfactory results. In refractory patients, electroshock therapy should be given serious consideration. Preferably, any somatic therapy should be followed with psychotherapy. In my experience the newer drugs have not been particularly helpful in depressions.

Large Myxoma of the Heart

Report of Case

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Neoplasms of the heart, both malignant and benign, are rare and relatively unimportant. All kinds of tumors, both primary and secondary, have been found in the heart.[1] Metastatic tumors of the heart are more frequently present and they are about 10 times as common as primary tumors. Metastatic tumors of the heart are usually secondary to cancer of the bronchus or of the breast.[1-3] Any heart chamber may be the site of a metastatic tumor; however, the right chambers are more often involved than the left because tumors are spread to the heart via the blood stream.

Primary tumors of the heart occur in one of every 2,000 autopsy cases.[3] Of the benign tumors, myxomas of the heart are of particular interest. These tumors usually involve the left auricle. They are diagnosed with great difficulty. Myxomas of the heart are usually polypoid and are attached by a pedicle in or near the foramen ovale. Occasionally, however, the tumor is flat and sessile.

The diagnosis of myxoma of the heart can only be established if suspected. A high index of suspicion, therefore, is a most helpful factor in establishing the diagnosis. Without this high index of suspicion, the diagnosis of the cardiac tumor is especially difficult. It is because of this lack of suspicion that in most cases the tumor is first recognized at autopsy.

Myxoma of the heart can be diagnosed. If diagnosed early, it is a correctable organic heart lesion. Because of this fact, all rare and atypical cases, with heart disease, should be suspect of tumor of the heart until proved otherwise.

Report of Case

A white woman, aged 49 years, 66¾ inches tall, and weighing 125 pounds, was admitted to the Florida Sanitarium and Hospital on March 10, 1957, complaining of extreme shortness of breath, extreme weakness, depression, mild cough, nausea and vomiting, all of three months' duration. She stated she had not felt well for the last three to six months. During this period she had became progressively weaker, fatigue being more and more pronounced. Slight exertion caused shortness of breath. Off and on, she had a moderate cough.

Past History.—The patient was first seen on Dec. 10, 1952. At that time she complained of severe swelling and stiffness of the joints of both hands, both feet, right elbow, right shoulder and both knees, which had been present for approximately five months. She particularly complained about the stiffness in her hands. The joint pain was so severe that it was crippling in character, and she had difficulty in walking. At that time she gave up her position as a state welfare worker. She was given aspirin and cortisone, and with these drugs the rheumatoid arthritis became well controlled. She was rehabilitated and went back to work. Approximately two years prior to the present illness she was given Meticorten and Bufferin, and this combination of drugs kept her completely comfortable.

On March 9, 1956, the patient was admitted to the Orange Memorial Hospital suffering from pneumonia and bilateral pleural effusion. She had been sick for approximately six weeks before hospitalization. At that time she was treated with oxygen, bed rest, and antibiotics, and after one month of hospital care and several weeks of convalescence, she returned to work as a welfare worker for the State of Florida.

On September 22, shortly after arising in the morning, the patient experienced a right hemiplegia while she was doing some housework. She was hospitalized in the Orange Memorial Hospital. The hemiplegia was transient in character and lasted approximately one day. She was discharged with a diagnosis of cerebral angiospasm. Following her discharge from the hospital, the patient apparently made a complete recovery, showed no residual paralysis or weakness of the limbs and shortly afterward returned to work. She, however, felt weak, listless and tired. At that time she was advised to stop working and to take additional rest at home.

On Feb. 3, 1957, she was again seen at home and then hospitalized because of severe weakness and shortness of breath. At this time she had orthopnea, and she had to rest on three pillows. She looked weak and ill, and her weight had decreased from 139 to approximately 126 pounds in approximately a six month period. L.E.-like cells were found, but their significance was indefinite. The roentgenogram of the chest taken at that time was reported by Dr. Robert W. Curry as showing findings that would be compatible with heart failure. The electrocardiogram was indeterminate, but could be interpreted as possible coronary insufficiency. Heart sounds were regular and rhythmic, and no murmurs were present. She was treated with bed rest, oxygen, Meticorten, Bufferin, Achromycin and Miltown for depression, and for the first time she was given digitalis therapy. She improved and was discharged to convalesce at home.

Present History.—On admission, the patient was acutely ill. She was lying quietly in bed, propped up on four pillows, and having difficulty in breathing. Her color was poor, and she had dark rings and shadows under both eyes. She was not feverish. She was well oriented and intelligent. She had no pain. Moving in bed caused a rather slight straining type of cough. The scalp was clean. There was no conjunctivitis, no iritis. The vision was good, the hearing was fair, and the nose was normal. Chest examination disclosed the chest to be flat. The apex beat, visible in the sixth interspace in the anterior axillary line and of a diffuse character, caused pulsation to be seen down to the upper portion of the abdomen. The heart was enlarged to the left. For the first time a murmur was noted. It was over the mitral

area and did not propagate into the left axilla. It was soft and systolic in type with possibility of a diastolic murmur. All of the other valves were intact. The heart rate was 90 beats per minute. On coughing, occasional diffuse rhonchi were heard over the chest on both sides. The liver was slightly enlarged, the abdomen was soft, and there was no tenderness or rebound tenderness. The fingers showed mild swelling in the joints, but there was good movement in the fingers, ankles and knees. No pedal edema and no muscle paralysis were present. Following her admission to this hospital, the patient progressively and rapidly became worse.

Laboratory Data.—Urinalysis on March 11 showed the color amber, specific gravity 1,020, pH 5.0, a trace of sugar, four to six pus cells, and an occasional epithelial cell and cylindroid. The hemoglobin determination was 75 per cent, color index 0.94, red blood cell count 4,000,000 per cubic millimeter and white blood cell count 11,700 with 1 per cent eosinophils, 8 per cent band forms, 69 per cent segmented forms, 20 per cent lymphocytes and 2 per cent monocytes. The reaction to the VDRL test was negative. On the next day, the antistreptolysin titer was 50 Todd units, and there was no C-reactive protein at two hours. On March 13, a search for L. E. cells gave negative results. The C-reactive protein, however, at the end of 24 hours was 2 plus.

An electrocardiogram taken on March 11 showed sinus tachycardia with auricular beats present. There were ST-T changes present which were of a nonspecific type and compatible with possible myocardial or pericardial damage. The significance of these findings was not definite. A roentgenogram of the chest showed the lungs to be slightly emphysematous with the heart definitely enlarged. There was no definite infiltration of the lungs, and the pleural margins were clear. Roentgen opinion was that configuration was somewhat suggestive of mitral heart disease. A barium enema study gave essentially negative results, and a gastrointestinal study showed no pathologic change in the upper portion of the gastrointestinal tract. Agglutination studies performed on March 28 gave negative results. A Bromsulfalein test showed 60 per cent remaining after five minutes and 30 per cent at the end of 45 minutes. Results of cephalin flocculation tests were reported as negative in 24 hours and 2 plus in 48 hours.

Course.—On March 16 the patient became partially deaf, a condition that had been intermittent. On March 20, because of nervousness, the administration of Equanil, previously given, was resumed. She felt better and looked better, and wanted to go home. The next day, severe anorexia and vomiting developed. Her color became extremely poor. The mitral systolic murmur became very soft, and no diastolic murmur could be heard. From that time on, changes were rapid and progressively downhill. On March 23 the liver, which had been slightly enlarged, was now two handbreaths below the rib margin, smooth and nontender. In spite of the enlarged liver, dyspnea improved. Two days later, she again began to vomit. On March 29 she was confused and disoriented and in critical condition. The abdomen became markedly swollen and distended, and the liver could not be felt. Blood cultures were ordered and then followed by the giving of large doses of penicillin, 1,000,000 units every four hours. The patient, however, lapsed into a coma and on the following day became increasingly orthopneic, in spite of being in an oxygen tent. After 16 hours of coma, she died.

Autopsy: Gross Examination.—Heart: The weight of the heart was 500 Gm. There was some opacity to the epicardium. The myocardium was firm and red-brown. There were marked dilatation and considerable enlargement of the right side of the heart, especially the right auricle. On the left side, there was a large soft edematous pedunculated mass attached to the wall of the left auricle, but the base, about 1 cm. in diameter, was very thin. The mass was approximately 8 by 3.5 by 3.5 cm. in size. It extended downward through the mitral valve to produce marked stenosis at that point. There was some thickening of the mitral valve cusp and definite thickening to the chordae. No verrucal lesions were noted on the valve leaflet. No regions of scarring were noted in the myocardium. The pedunculated mass had a yellow-gray color with scattered regions of dark red.

Microscopic Examination.—Section through the left auricle, through the base of the polypoid mass showed a sharp break in the subepicardial connective tissue and a change in the orientation from horizontal to the perpendicular orientation of the fibers which blended with the base of the polyp. The polyp was seen to be composed of essentially two types of tissue which blended imperceptably with each other. In one type there was pink amorphous, somewhat granular material resembling fibrin in which there were embedded numerous red blood cells. In these areas, actual cell content was scanty. Those present were small spindle type. In other regions, there was a more cellular proliferation with many blood vessels, and the intervening stroma had a pale glassy gray appearance. There were also present regions of diffuse hemorrhage. There was no evidence of any rheumatic activity, but a section through the mitral valve showed some thickening of the chordae.

Discussion

Any case in which the patient has unusual or atypical complaints with a possibility of a presumptive diagnosis of heart disease should always be considered as a possible case of tumor of the heart. Frequently, the primary complaints are periodic weakness, coughing, minor cerebral vascular occurrences, and signs of right congestive failure.[1] This tumor may also cause a form of ball valve obstruction giving similar findings to those of mitral stenosis. The symptoms will vary with the location and the size of the tumor. It has been stated that all tumors causing symptoms are large. The tumors, frequently, will impinge on the mitral valve area. Because of this impingement, myxomas may simulate rheumatic valvular heart disease with mitral stenosis. Peripheral emboli may be caused by detached pieces of tumor.

The following differential points[2] are important: (1) There is no previous history of rheumatic fever. (2) There is a variation in the murmur secondary to the change of the position of the patient. This is a most important differential finding. (3) The blood cultures are repeatedly negative. The upright position usually increases the murmur, and lying down either decreases or causes the disappearance of the murmur. This response is the exact opposite of the findings in true mitral stenosis caused by rheumatic fever. If the myxoma has a broad base and is not polypoid, the murmur will not change with body position if a murmur is present. Occasionally dyspnea, palpitation, cyanosis, faintness, syncope and even shock occur suddenly with the change of the body position because of the mechanical obstruction of the flow of blood through the mitral valve.

Eventually, myocardial failure results. This

failure is refractory to digitalis or other recognized forms of heart therapy.

The physical examination is as described in the case presented. The possibility of a tumor of the heart should always be considered in all atypical cases of cardiac disease. It is repeated, a high index of suspicion is almost a must in the diagnosis of this disease.

The electrocardiogram is indeterminate.[3] Occasionally, an irregular flutter or fibrillation may be present and this may be transient or permanent. Occasionally also, the electrocardiogram may show the presence of atrioventricular or bundle branch block or T-wave changes.

Roentgenograms of the chest will show an enlargement of the left auricle and occasionally an enlargement of the right cardiac chambers.[3]

Angiocardiography is a substantial help in the diagnosis.[4]

Until 1952 no attempt was ever made at surgical correction of this disease.[1] At that time surgical removal of a myxoma was attempted unsuccessfully. It is the consensus of cardiac surgeons that if this condition is diagnosed early, it is correctable. It is also thought that the direct approach is the best approach.

Conclusion

A case of myxoma of the left auricle is described.

This lesion was not diagnosed antemortem because of the low level index of suspicion. All the classical signs and symptoms were present to help establish a diagnosis.

Any unusual disease state with findings indicating cardiac disease should be suspect as a tumor of the heart.

With early diagnosis and proper surgery, myxoma of the heart is a correctable disease.

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Prolapsing Trigonal Mucosa in Infant

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The following report is of a case seen in June 1958 which is similar to the one reported by Espinosa, Blanco, and Picornell[1] in the Journal of Pediatrics that same year. They covered the background well and reviewed the accumulated literature.

The patient, the third child of the family, was three weeks old when first seen. The other two children were living and well, as was the father, aged 30. The mother, aged 23, had a history of some "kidney trouble."

The child was born on May 29 by normal breech delivery and weighed 5 pounds, 10 ounces. At three weeks, she was taking breast feedings and gaining and growing normally with no complaints except straining at stools.

About 10 a.m. on the morning she was seen, she started screaming. The mother checked her, changed her diaper, and found a red and white streaked mass protruding from the vagina. Some pus was present. She immediately took the child to the family physician, who found the protruding mass on examination. When manipulated, the mass produced a rather purulent discharge and suddenly deflated, pus and urine appearing. When left alone a minute, it filled up again. He referred the child to my office (pediatric).

Physical examination revealed a normal infant three weeks old with no abnormalities except in the rectal and genital areas. The rectum was extremely tight, and considerable stretching was necessary. Blood was present following examination. In the genital area, there was a large, red mass about ½ cm. in diameter which extended out fully 2 cm. (fig. 1). No blood was present. On reflecting the mass and pushing it posteriorly, urine suddenly appeared with an occasional purulent discharge. The vaginal area was opened, and a probe was introduced with no difficulty. A cotton applicator was placed against the cystic mass to manipulate it, and the mass eased back through the urinary meatus into the bladder area with gentle pressure. It, however, immediately prolapsed again.

The impression at that time was that it was a cyst or a fistula of the bladder wall which had

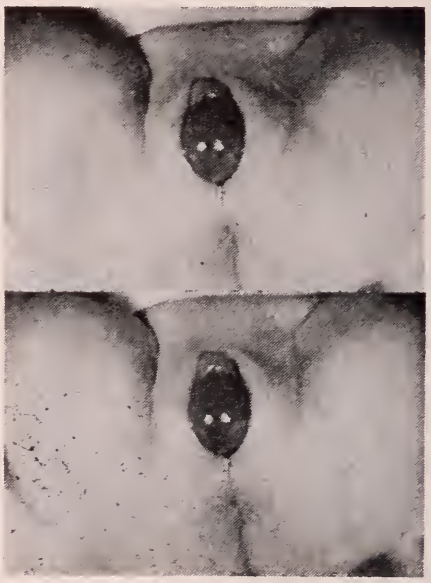


Fig. 1.—Presenting physical findings at the time of the initial examination.

pedunculated out through the urinary meatus.

The child was admitted to the hospital with that diagnosis for further care. A Foley catheter was tied in place, and the bladder was held in normal position by that method for approximately 48 hours. With the patient in the dorsal lithotomy position, the cystoscope was introduced into the bladder under local anesthesia. Inspection revealed pronounced edema and hyperemia, but no definite abnormality could be noted. A profuse prurulent discharge was obtained through the cystoscope and was washed out around it. The instrument was then introduced into the vagina, and that area appeared essentially normal, except for irritation. No source could be found for the protruding mass. Intravenous pyelograms were normal in appearance.

The child has done well following discharge from the hospital. She has been under observation for one year with no recurrence of urinary trouble.

The case is of interest in that it is apparently another case of prolapsing trigonal mucosa.

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Use of a PETN-Ataractic Combination (Cartrax)* in the Long Term Management Of the Cardiovascular Geriatric Patient

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Geriatric patients are constantly increasing in number and seeking medical care. A large share of this care becomes the responsibility of the general practitioner. Old age brings its own array of disorders, but often heading the list of symptoms are variations of cardiovascular complaints, such as angina pectoris associated with arteriosclerotic heart disease and headaches of hypertension. These older patients frequently have accompanying emotional problems and anxiety neuroses; thus, they seek not only relief from their physical symptoms but peace of mind and freedom from health worries as well.

Florida, within recent years, has become a mecca for retired and semi-retired persons desirous of relaxing during their declining years and enjoying these years to the fullest. Hence, more geriatric patients are seen by the Florida physician than are perhaps encountered daily by the general practitioner elsewhere throughout the country. My Florida practice is comprised largely of elderly adults, many of whom present symptoms of cardiovascular disturbances.

Nitroglycerin in the treatment of heart diseases has long been recognized as a substance for effective and immediate relief of the acute attack; however, for more prolonged response, clinical studies by Russek, Zohman and Dorset[1] and others have shown pentaerythritol tetranitrate (PETN) to be more effective prophylactically and more desirable for prolonged use. In certain cases PETN has replaced nitroglycerin altogether,[3] although it is not intended for immediate relief of anginal attacks. PETN is a slow-acting organic nitrate compound with coronary vasodilating action ascribed to the release of the nitrate ion in the body. Chemically it bears a close structural resemblance to nitroglycerin; PETN releases smaller amounts of nitrate for longer periods, thus making it particularly suitable for prophylactic use against the anginal syndrome. Recent clinical studies[4,5] have shown PETN improves electrocardiographic response to exercise, lessens the frequency of anginal attacks, and, when compared with other drugs, is of definite benefit in angina pectoris. PETN produces little effect on the heart rate; however, moderate increase in the rate and volume of respiration can be expected with this agent.

It is recognized that psychic and neurogenic influences play a role in the production of cardiac disturbances. Attacks are often precipitated by emotional tension. Both pleasant and unpleasant thoughts and experiences may act as triggers in bringing on attacks.[6,7] Many physicians have found tranquilizers a valuable adjunct in the therapeutic regimen of these patients. Hydroxyzine hydrochloride is an established ataractic agent which has been shown in pharmacological studies[8,9] and in clinical trials to produce an ataractic effect without depressing the higher centers of the central nervous system, and without disturbing mental faculties or mental acuity. Its particular value for the cardiovascular patient lies in its ability to produce calmness and peace of mind. Some persons may experience a feeling of sudden release from tension and apprehension, which is beneficial in angina pectoris and which may at first be accompanied by a slight drowsiness. Drowsiness usually disappears after the first two or three days of therapy, but a feeling of serenity persists. Aside from its tranquilizing effects, hydroxyzine hydrochloride (Atarax) has been shown to have value in cardiac arrhythmias[10] and angina cruris[11,12] as well as an ability to block selectively the effect of epinephrine and to increase coronary flow in anesthetized dog and cat hearts.[13]

*J. B. Roerig and Company, Division, Chas. Pfizer & Co., Inc.

It was thought that a clinical trial of a combination of these two drugs would be of definite value in the long term management of the cardiovascular problems of the geriatric patient. This paper reports the results of this trial.

Materials and Methods

Seventy-seven patients, mostly elderly adults, were treated for a period of over two years. Eighty-seven per cent of these patients were over 50 years of age. Table 1 shows the age range. As would be expected in this age group, most of the patients presented multiple complaints; a listing of their major diagnoses is presented in table 2. Most of the patients showed evidence of some form of cardiovascular disease; many had a general circulatory impairment manifested by such symptoms as dizziness, angina and leg cramps. One main feature common to many of these patients was a need not only for a vasodilator but for some form of sedation. Cartrax,* a combination of PETN and hydroxyzine hydrochloride, was chosen for this study.

The dosage ranged from 10 mg. tablets three times a day to 20 mg. tablets four times daily. There was less need for increasing dosages of the sedative as is frequently found necessary in patients receiving phenobarbital for long periods. A 10 mg. dosage given at four to six hour intervals has not been changed in some of these patients for a period of over two years.

Table 1. — Age Range of Patients In Cartrax Study

Age Range	Number of Patients
35-39	3
40-49	7
50-59	15
60-69	29 (87% over 50)
70-79	19
80-89	4
Total	77

Table 2. — Diagnosis and Sex of Patients In Cartrax Study

Diagnosis	Number of Patients	Men	Women
Generalized arteriosclerosis	12	8	4
Arteriosclerotic heart disease	35	16	19
Essential hypertension	20	4	16
Hypertensive cardiovascular disease	5	2	3
Obesity, menopause, et. cetera	5	0	5
Total	77	30	47

Table 3. — Summary of Clinical Results With Cartrax

Diagnosis	Number of Patients	Results Excellent	Good	Poor	Side Effects
Generalized arteriosclerosis	12	10	2	0	0
Arteriosclerotic heart disease	35	23	3	4	0
Essential hypertension	20	17	0	3	1
Hypertensive cardiovascular disease	5	3	1	1	2
Obesity, menopause, et cetera	5	4	1	0	0
Total	77	62	7	8	3
Per cent	100	80.5	9	10.5	3.3

Results

The patients in this series did as well on Cartrax, if not better, than those patients on nitroglycerin or the long-acting nitrates. More than 89 per cent showed a response classified as either excellent or good (table 3). A further benefit, especially noted, was that the depression often accompanying long term administration of the barbiturates was rarely observed in the patients receiving Cartrax.

The benefit of Cartrax in those patients who had previously taken large quantities of nitroglycerin was obvious. When they were given Cartrax four times a day in 10 or 20 mg. strength, the need for additional nitroglycerin tablets was markedly curtailed or entirely eliminated. One patient reduced her requirements from 20 to 75 nitroglycerin tablets per day to only an occasional sublingual nitroglycerin tablet after taking a shower. This reduction occurred after she had started on Cartrax, 20 mg. four times a day. She has been receiving the drug for almost two years now and has shown no indication of need for other medication.

In addition to the help many patients with angina pectoris have received from Cartrax, many persons who had nocturnal leg cramps have shown improvement. Most of these were older women with evidence of generalized arteriosclerosis as their main problem. Initially, they received Cartrax, 10 or 20 mg. four times a day, but later most of them were able to reduce the medication to one tablet at bedtime with complete remission of symptoms. The drug was not found to be effective in the treatment of intermittent claudication, which was seen more frequently in the male patient. It seemed, however, to be useful in the treatment of cerebral arteriosclerosis in elderly patients. It is especially valuable as a general supportive drug which is reasonably safe and easy

*Cartrax tablets are supplied in concentrations of Atarax 10 mg. combined with PETN 10 mg. (yellow tablet), and Atarax 10 mg. combined with PETN 20 mg. (pink tablet).

to administer. The combination of the sedative and the nitrate reduced the need for taking two tablets, a frequent problem in this age group, since many patients are often taking nitroglycerin, digitalis, vitamins, and other medication. When given Cartrax, these patients seem to sleep better, have a clearer sensorium during their wakeful hours and, for the most part, appear more sociable. How much cerebral circulation is induced is difficult to determine, but the results lead one to believe it is improved with this combination of drugs.

Discussion

A combination of hydroxyzine hydrochloride with pentaerythritol tetranitrate has an advantage over the use of the nitrate alone, as witnessed in a number of these patients who were previously receiving PETN alone. This combination of drugs is most effective in the initial treatment of mildly hypertensive patients prior to the use of any specific antihypertensive drugs. In many, potential hypertension could be controlled by the administration of Cartrax, 10 mg. three times a day, with a simple weight reduction program and a restricted sodium intake without need for further medication. Understandably, many of these hypertensive patients would fall in the labile group and may well have improved without the drug; nevertheless, it did offer an adjunct in the management of this type of borderline hypertensive patient.

Report of Cases

The following case reports are typical examples of the action of this drug combination:

Case 1.—An 87 year old widow had pronounced generalized arteriosclerosis with cerebral impairment and progressive signs of senility complicated by hypertensive cardiovascular disease. She showed some agitation, marked impatience with her domestic help and friends, and unwillingness to cooperate with her physician. She was becoming most forgetful and was unable to manage her finances as she had done prior to this time. The hypertensive cardiovascular disease was managed with digitalis leaf, 1½ grains daily, plus Diuril, 0.5 Gm. twice a day, supported by Cartrax, 20 mg. four times a day. After some six weeks, there was a decided change in her general sociability and mental attitude. She became active again in her social group and is once again leading a happy and useful life.

Case 2.—A 67 year old retired man with cerebral arteriosclerosis, arteriosclerotic renal disease, arteriosclerotic heart disease, benign diaphragmatic hernia and a low grade chronic bronchitis had a blood pressure range between 140 to 190 mm. Hg. systolic and 90 to 110 mm. Hg. diastolic. He had been in Florida some 10 to 15 years since retirement and had been active in yacht and country club as well as several side business ventures until 18 months prior to consulting me when cerebral impairment necessitated his withdrawal from these activities. Kynex, one tablet daily, for the renal infection and Cartrax, one 20 mg. tablet four times a day, were prescribed. Since that time he has made a gradual return to a more social life and is now playing golf at least twice weekly, which would have been impossible 18 months previously.

Case 3.—A 37 year old housewife with three children consulted me with the chief complaint of poor circulation and general nervousness. There was a history of rheumatic pains since early adulthood and of borderline hypertension. Physiological and psychological examinations led to the conclusion that the patient had essential hypertension with an emotional overlay. Cartrax, 20 mg. four times daily, was prescribed. She showed immediate improvement and now has fewer subjective complaints. She requires only an occasional office visit whereas previously she was seen as frequently as twice weekly. She has been on medication for approximately 12 months and states that she is comfortable as long as she takes her medication. Medication was discontinued for about two or three weeks with the return of symptoms and increased blood pressure findings. These were improved with the reinstitution of Cartrax.

From the over-all findings in this study as well as from personal observation in over 100 other patients given Cartrax in the past few years, it can be said that this drug has been well tolerated when used with and without other medication. It has been free from any serious side effects. The only noted side effects in this group were one case of headache, two of generalized flushes including facial flush, and some few complaints of nightmares. The beneficial results, especially in hypertensive patients, certainly lead to the belief that the mild cases of essential hypertension can be better managed with such an innocuous drug without fear of the side effects observed with some of the Rauwolfia products and the other more potent antihypertensive drugs.

Conclusion

The value of this combination has been observed. The addition of hydroxyzine hydrochloride to the phenylnitrate vasodilator has given additional benefit, primarily from a relaxing standpoint. It might be said that the over-all improvement has been more than simply additive, but when two drugs are administered to a person with more than one malady, the evaluation of a particular drug or drugs is most difficult. Many of the patients had multiple diseases requiring more than one medication. Many had arteriosclerotic heart disease with some form of congestion requiring the digitalis preparations and/or the diuretics and, possibly, an antihypertensive drug. When a second, third or fourth drug, such as Cartrax, is added, an honest evaluation as to the patient response is difficult to achieve.

Yet, even with this difficulty in mind, there was demonstrable evidence shown both subjectively and objectively in the majority of the patients receiving this drug. These patients were seen as private patients on routine office visits and were not under the strict clinical observation available in large teaching centers. Nevertheless, these are the kinds of persons who benefit most from the newer drugs available in the management of diseases of old age. In the management of geriatric patients, who may be taking several different drugs, a combination drug such as Cartrax obviates the need to administer two different pills since the sedative and the vasodilator are combined in the one tablet.

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The Patient's Responsibility in Improved Medical Care Today

Allen Shepard, M.D.

KEY WEST

The physician's role in creating a rift in the marriage of modern medicine and the patient has been editorialized in both medical and lay publications. Little has been said of the patient's responsibility in making this relationship a successful one. Nothing has been said of the influence of newspapers, magazines, and science editors over this relationship.

We are told that doctors today are allowing scientific tests and miracle drugs to provide a short cut, not always successful, to the cure, without demonstrating compassion for the patient in his illness. We are told that some doctors cannot be reached in emergencies and that they spend too little time with each patient. Patients also charge that doctors' fees are too high and that they make mistakes in diagnosis and treatment. Certainly these complaints are justifiable in some instances. Yet these complaints clearly show that the patient may have failed in his responsibilities.

Doctor-Patient Rapport

First of all, the patient today frequently comes to the doctor with a preformed opinion of what is wrong with him and what should be done about it. This is not entirely his fault. He has been educated over the years in medical lore by newspapers, magazines, television and motion pictures, and by the doctor himself. This patient, having a preformed opinion of his diagnosis and treatment, accepts advice skeptically and displays little sincere interest in the doctor or the compassion displayed by him. Since education of the lay public has dealt almost exclusively with the highly technical developments in medical science and the so-called miracle drugs, it is little wonder that many patients seek treatment of their ailments without an appreciation of the compassion displayed by the doctor and its importance in helping them to get well. Technical discoveries and miracle drugs naturally make more interesting material for the layman to absorb than the less spectacular accomplishments of the kindly, sympathetic, devoted physician. Sympathetic attention can only come from the patient's respect for the capacities of his doctor and a sincere interest in what he has to say.

The reaction we call "sympathy" also means "harmony, and the sharing of feelings and interests." There are few doctors who cannot recall incidents such as this: After completion of the history and examination of Mrs. X, the doctor then begins, unhurriedly, an explanation of his opinion as to what is wrong and what is the best thing to do to help clear up the trouble. During the course of this explanation, the physician is interrupted repeatedly by Mrs. X. Written instructions and a prescription are given to Mrs. X. Later in the day, Mr. X telephones the doctor asking what he found wrong with his wife, because the doctor did not tell her much about it, just wrote a couple of prescriptions. Mrs. X's inattentiveness destroyed the rapport that should exist between her and the doctor, and probably deprived her of the benefits of her doctor's skill and patience.

Emergencies

Although it may seem that the patient bears little responsibility in the availability of doctors for emergencies, such may not be the case. The doctor responding to an "emergency" call may find a nonemergency condition of several days or weeks duration. This dampens his desire to respond to so-called emergencies. Then, too, many times simultaneously, several physicians will be called for a single patient with an emergency illness. Most physicians do not regret having been called for a true emergency, even though their service is superfluous, but some doctors have needlessly had to leave patients in their offices who have traveled considerable distance to be treated. Doctors themselves in many areas have organized emergency call services, so that a doctor can always be reached in true emergencies. The patient is not expected to diagnose his own ailment. If, however, he will use common sense

and maintain respect for the doctor's time in asking for emergency treatment, then such treatment will always be available.

The intelligent patient realizes that the length of time the doctor spends with him is not a criterion of his competence. Time spent with the patient may merely reflect the difficulty or ease of examination, diagnosis, and treatment. Whether the patient feels that the amount of time spent with him is adequate is influenced by his attentiveness, emotional makeup and personality. Then, too, it is often the patient, and not the doctor, who is in a hurry. Today it is common for the visit to the doctor to be planned along with a stop at the supermarket, a haircut for little Johnny, and a stop at the bank before 2 p.m. closing. With the preoccupation of these chores to be accomplished following the visit with the doctor, the patient has heard little of what the doctor has said. The impression that lingers, however, is that the doctor "just didn't spend much time." Yet it was the patient, not the doctor, who was "in a big hurry."

Remuneration

Medical ethics dictate that the prime object of the medical profession is to render service to humanity, and reward or financial gain is a subordinate consideration. That the vast majority of physicians adhere to this ethical principle is a certainty. The practicing physician today is faced with financial obligations identical to those of the artisan, merchant, vendor of services, and others. He must purchase licenses, maintain a place of business and necessary equipment, engage employees, keep records, pay taxes on property owned and on income earned, and make donations to local and national charities. In addition, the physician subscribes to medical journals, attends medical conventions and postgraduate courses, all of which create additional expense. This is necessary in order for him to maintain proficiency. The public expects this of the doctor. To expect a fair fee for service to the patient must certainly seem logical.

The patient must realize the necessity and importance of the doctor being properly rewarded. Unless this is so, the scope of service rendered would be narrowed tremendously. Despite this, no human being in these United States need be deprived of the finest in medical care, thanks to the charity in the hearts of doctors and laymen alike. It is often difficult for the patient to evaluate "service" which has such an ethereal character. He should delay forming conclusions regarding the fairness of a fee until he has asked the doctor to explain the basis for his charges. The patient who indulges in a masquerade of ignorance about the financial aspects of medical care violates the Golden Rule. The frankness with which the patient and his doctor discuss the financial aspects of illness will often eliminate the element of dissatisfaction arising from fees.

For the doctor to be frank about discussing his charges should not be misconstrued by the patient as "commercialism." Few doctors today have the desire or inclination to appear "commercial." To avoid this, most will hire employees to handle the billing of patients and other chores of a "business" nature. This aid permits the doctor to devote all of his time and energy to the treatment of his patient.

That doctors make mistakes in diagnosis and treatment serves as a further demonstration that the practice of medicine has for its most important ingredient the quality of being humane. To err is human. Despite all the technical discoveries in medical science and the great care taken by the physician in his treatment of the patient, errors in diagnosis and treatment will occur. The physician is human. It is a tribute to him that he has erred so little.

There are many patients who seek medical treatment for ailments which may have a pecuniary background. Workman's compensation insurance, accident insurance, disability pensions, and public liability insurance have created situations where the patient's primary concern will be financial reward as a result of illness. The patient in such circumstances seeks little in the way of sympathetic attention. He visualizes his illness as a bonanza. The doctor is seen only faintly in this vision. The physician finds it difficult to assume his proper role as a healer unless the patient's objective is parallel to his.

"The Open Sesame" to the finest medical care in the world cannot be provided by the physician himself. The patient, by his attitude and intentions, bears a portion of the responsibility in assuring success in the prevention, diagnosis, and treatment of illness.

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ABSTRACTS

Management of Women With Positive Vaginal Cytological Findings. By James H. Ferguson, M.D., and J. Allan Offen, M.D. J. A. M. A. 170:1892-1895 (Aug. 15) 1959.

Cervical and vaginal cytological studies are rapidly becoming routine diagnostic procedures in the examination of women. By obtaining smears from all gynecologic and obstetric patients, the authors have acquired experience with many thousands of cytological examinations of the cervix. In their opinion every woman deserves a cytological examination on the first visit, regardless of age or whether or not she is pregnant. Punch biopsy is performed in all cases of cervical lesions. When a histological diagnosis of intraepithelial carcinoma is made or when there is an unexplained positive smear, a cold conization of the cervix is performed.

With the expanding number of such examinations, there are large groups of women who have positive findings on cytological examination and in whom frank malignancy does not exist. Appreciation of the size of this group and of the ramifications of the problem they present will inevitably increase. Management of these patients therefore looms as the newest challenge confronting gynecology.

The Lymphoid Tissue of the Nasopharynx. By A. R. Hollender, M.D. Laryngoscope 69:529-542 (May) 1959.

The relationship of the lymphoid tissue of the nasopharynx to its own space, to other parts of Waldeyer's ring, and to the body as a whole presents a problem of broad clinical significance. Dr. Hollender points out in this article that present knowledge holds to the belief that the functions of the lymph structures of the nasopharynx are similar to those of the general lymphatic system, and that among the several concepts advanced concerning the growth and involution of lymphoid tissue the one pertaining to a hormonal-lymphoid relationship merits special consideration. He observes that the incidence of nasopharyngeal lymphoid hyperplasia in older persons is relatively high, atrophy of this tissue not being an invariable development of advancing age as generally assumed. Of the various clinical problems associated with hypertrophied nasopharyngeal lymphoid tissue, the complications which develop in the respiratory and auditory organs give the otolaryngologist the most concern.

Failures in the management of nasopharyngeal lymphoid tissue can often be accounted for by inadequate extirpation, lack of regard for a possible generalized lymphatic disorder, and absence of an effective method with which abnormal regenerative activity of the lymphoid organs can be controlled or completely retarded. Theoretically, the ideal would be a method of prevention, adequate control of allergy and reinfections of the upper portion of the respiratory tract in infancy and childhood, or following surgical intervention. Hope rests, the author concludes, in advances in hormonal preparations through whose effects the activity of the entire lymphatic system could be adjusted or regulated permanently as the indications warranted.

β-Hemolytic Streptococci From Several Sources Reactive in Both Groups A and F Antisera. By Milton S. Saslaw, Madelyn Saul, Sallie Anne Jenks, and James M. Jablon. J. Bact. 77:519 (April) 1959.

In an investigation of the epidemiology of β-streptococci in Miami, all streptococci recovered, approximately 3,000 cultures, were grouped, the organisms belonging to group A, B, C, F, or G, or being nongroupable. In February 1958, a culture taken from an excised, minced tonsil yielded a β-hemolytic streptococcus, which, after isolation, was observed to react to both group A and group F antisera (Difco). After this observation was made, three additional persons were found to harbor organisms which reacted with both A and F antisera. Three of the AF cultures were carried through 12 successive generations, and maintained the trait of grouping with both A and F antisera. Further investigation of the AF organisms is in progress.

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PRESIDENT'S PAGE

The Last Bulwark

It is singularly appropriate that this page is being written on July Fourth. Even every school child knows that the celebration of that date commemorates the signing of the Declaration of Independence. That event, setting forth a statement of principles by which free men might live and govern themselves, marked the beginning of a new nation with a new and radically advanced form of government for that day. This is our proud heritage.

Now, after nearly two hundred years of this democracy, we find that government of some of the people, by a comparatively few of the people, for a vocal minority of the people, is gradually and with little opposition withdrawing the freedom so doggedly won.

Over the years, the so-called learned professions—medicine, law and theology—have been leaders in independent thought and action. And of these, physicians are considered to be the great individualists. That is to be expected. Disease can be categorized, but not patients. Such people cannot be cured with a do-it-yourself kit. Treatment requires individual consideration of the patient. Thus the physician has become accustomed to thinking and acting independently.

The question then arises whether physicians are willing to fight for their inalienable and traditional rights—to practice their art to the best of their abilities, to treat the needy without cost if need be, to decide for themselves how their services shall be used.

Is freedom so trivial a thing that it can be traded away for the flimsy argument that compulsory medicine, call it what you will, is a necessity for the good of all?

I have no patience with those who would accept complete government control of medical practice as being so inevitable as to be considered a *fait accompli*. It is not yet.

Determined action by all of us, not just your officers and committee chairmen, can controvert the apparent trend. Are we so impassive, so impecunious, so impotent as to take this latest and most dangerous threat to free American medical practice without a fight for our rights? I think not.

Leo M. Wachtel

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The Doctor and the Hospital

Today the spotlight of popular attention has focused itself on the socioeconomic problems of Medicine, and the traditional priority of its professional aspects has waned. Such fission between two aspects of medical practice has been perhaps nowhere as evident as in the hospital arena. Here the interests, the responsibility and the points of view of those responsible for the professional care of the patient and those responsible for the administration and the financial aspects of this care have drifted farther and farther apart until they represent, in many instances, two entirely separate operations. This unfortunate dilemma is universal and has been highlighted by the differences of opinion on basic issues between hospital and medical associations. This is a national trend, which, if it continues, will become a national catastrophe.

Most of us have experienced, at first hand, evidence of the antipathy between hospital boards and medical staffs. Most of us have seen these two groups approaching the solution of a common problem in belligerent, uncooperative attitudes which seem more concerned with fixing blame than with correcting unsatisfactory situations. The undeniably important problem of the high cost of medical care and its explosive, fungoid growth is a serious and a pressing one. It is a problem that concerns our patients and ourselves, and it will never be solved by the useless effort of pointing out that the increase is largely in hospital administrative costs and not in Physicians' fees. Patients have a right to look to us—their Physicians—for guidance, help and remedial care. They turn to us as they helplessly and involuntarily enter the medical arena and expect us as experts in this discipline to guide and direct them in all of its aspects.

Somehow we have avoided the responsibility, the difficulty and the unpleasantness associated with problems arising in the administrative field of hospitalization and medical care, and have become separated from the direct supervision of many of the aspects of the welfare of the patient under our care. Regardless of how this began, it would appear essential that it be corrected if any real advance is to be made upon the over-all problem of furnishing competent medical care to all the people at a total cost which they can afford, anticipate and prepay.

Physicians—and Physicians *only*—can effectively control hospitalization. certain portions of hospital expense and efficient hospital administration; and the individual Physician must once again walk the hospital ward with authority, responsibility and interest in all the details of professional and administrative problems. He must once again sit on the boards of control of hospitals in sufficient preponderance of numbers to influence their thinking and to guide and control policy and performance. We can no longer afford the luxury and the indolence of preferring to deal solely with interesting professional problems. We certainly—above all others—are responsible for the total care of the sick. Until we individually accept this responsibility—until we make of this tremendous national problem a grass roots issue, solved in its fractional components by each of us individually participating in our own hospital administrative, as well as professional, problems—until then, we shall not make worth while progress.

We must accept the responsibility, and we must have the opportunity to do so—an opportunity which can, in most instances, be granted only by an enlightened hospital board. Successfully allied, the Doctor and the hospital will then represent one medical point of view—one unified, constructive approach to the difficult problem of present day medical care. If it is not accomplished, the hospital will be gradually separated from the great profession of Medicine, and will assume the cold, bureaucratic aspect of another governmental department, and the Physician and his patient will be lonely, indeed. Let us show the Nation that the Doctor and the Hospital are a fraternal, cooperative team, ceaselessly, sincerely striving to provide better medical care for all.

J. W. A.

By Trial — By Error

Barracuda Poisoning

About three and a half years ago, I had the opportunity to observe five cases of poisoning from barracuda. The five men were Guatemalan sailors on a small tramp steamer in the Bahamas. They caught a small barracuda and, welcoming a change in diet, prepared the fish and ate it. Some was also fed to the ship's cat, which within 12 hours became violently ill; paralysis of its hind legs developed, and within 24 hours it was dead.

Soon afterward, the men became nauseated and began to vomit. By the following day, upon their arrival in Miami, they were still vomiting, completely prostrated and dehydrated. They were immediately hospitalized in a small nursing home.

I telephoned orders for daily infusions of calcium gluconate, one of the recommended treatments for barracuda poisoning. Somehow, however, the orders were misinterpreted and instead of the calcium gluconate, one-half gram of procaine hydrochloride was used in the intravenous infusions.

To my surprise, these men did very well for the next two days. The nausea and vomiting cleared up much faster than was expected. It was then that one of the nurses told me that she was giving these patients procaine hydrochloride instead of the calcium gluconate. The error was corrected, and the men were given calcium gluconate.

During the next three days their condition reversed itself, much to my astonishment. Their happy progress ceased abruptly; they became sicker and sicker. At this point, I changed the infusions back to procaine hydrochloride in normal saline. The next day, I was pleased to find that there had been a little improvement. Within a week, these men were up and about, eating well, gaining weight and feeling fine. It was at this point, unfortunately, that they were put on a plane and flown back to Guatemala, so that I lost contact with them.

Obviously, five cases of barracuda poisoning treated with procaine hydrochloride infusions do not prove very much. I believe, however, they do prove definitely that when a physician is presented with such a case in which the patient is doing poorly under the usual treatment, a change in therapy is indicated, possibly to procaine. Thereby, either

confirmatory or negative statistics as to the value of this drug will be obtained. Unfortunately, since that one occasion, I have seen no more cases of barracuda poisoning nor any other type of fish poisoning.

There are neither physical nor chemical tests for this poison and indeed there is no knowledge of its chemical nature. Only certain barracuda show evidence of it, and it is believed that they obtain it from eating blowfish whose livers are violently poisonous but whose back muscles are considered a delicacy.

As to local folklore regarding this poison, I have talked with a number of fishermen including natives of the Bahamas. They told me that they can determine which barracuda are poisonous and which are not by exposing the fish on the docks. Those fish to which flies are attracted are safe for human consumption. Those that the flies avoid are invariably poisonous. The fishermen also stated that in the evening when the docks are cleaned off and remnants of the fish disposed of into the sea, the sharks that come in during the night will eat all types of the refuse with the sole exception of the barracuda. These remains may be found floating on the surface of the water the next day.

Evidently, man and mammals have no way of recognizing this poison, though the flies and sharks can recognize it and avoid it.

Herbert F. Gross, M.D.
Miami

Dr. Louis M. Orr. Retiring President American Medical Association Honored With Awards

It is peculiarly fitting that the President of the American Medical Association should receive as well as bestow awards, especially when he is so distinguished a medical statesman as Dr. Louis M. Orr of Orlando, who retired as President of that body at its 109th Annual Meeting, held in Miami Beach in June. Among the honors conferred upon Dr. Orr was a citation from the Boy Scouts of America, now celebrating its Golden Jubilee year. The citation was presented in recognition of the support given that organization by the medical profession. A citation was also awarded by the Medical Advisory Board of the Sears-Roebuck Foundation. This honor was accorded him for his service to organized medicine during the year that he held medicine's highest post. In addition, Dr. Orr became the first recipient of "The Purdue Frederick — American Medical Association Presidental Award," which will hereafter be presented annually. The unique award, an elaborate hand-sculptured crystal vase, depicting the historic march of medicine in the conquest of disease, honors the chief representative of the nation's physicians who is called upon each year to serve as spokesman for the



A citation in appreciation of the medical profession's support to the Boy Scouts of America is presented to Dr. Orr by Royal B. Stone, Assistant Director of the Health and Safety Service, Boy Scouts of America. The organization is celebrating its Golden Jubilee this year.

To develop physician leadership in promoting cooperative efforts with allied health professions and services, the report suggested the following A. M. A. activities: (1) the holding of a general conference with allied scientists in the basic medical sciences and related disciplines for discussion of matters of common concern related to the creation of permanent, cooperative activities; (2) the holding of specific exploratory conferences with members of segments of science allied to a given area of medical practice with the national medical organizations concerned; (3) the holding of general and specific conferences with professional and technical assistants on education, recruitment and coordination of contributions; (4) through meetings and publications, provision for reciprocal exchange of information between physicians and allied scientists and members of health professions; and (5) establishment of effective, continuing liaison between A. M. A. representatives and professional and technical personnel.

National Foundation

With regard to relations between the medical profession and the National Foundation, the House adopted a statement of policies for the guidance of state medical associations and recommended that they be adopted by all component medical societies. These policies cover such subjects as membership of medical advisory committees at the chapter level, the function of these committees, the basic principles concerning financial assistance for medical care, payment for physicians' services and physicians' responsibilities for constructive leadership in medical advisory activities.

The House also directed the Board of Trustees to authorize further conferences with leaders in the National Foundation on the problem of poliomyelitis as it relates to the betterment of the public health and to consider further joint action toward the eradication of polio. The House commended the National Foundation for its outstanding service in the attack against polio, but pointed out that much work remains to be done in public education, vaccination, continuing assistance for polio victims and continued research.

Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House strongly reaffirmed its support of the Blue Shield concept in voluntary health insurance and approved specific recommendations concerning A. M. A.–Blue Shield relationships; agreed that the American Medical Association should sponsor a second National Congress on prepaid health insurance; and directed the Board of Trustees to develop group annuity and group disability insurance programs for Association members. It also reaffirmed its opposition to compulsory inclusion of physicians under Title II of the Social Security Act and recommended immediate action by all A. M. A. members who agree with that position; urged reform of the federal tax structure so as to return to the states and their political subdivisions, their traditional revenue sources; and approved the objectives of the A. M. A. Commission on the Cost of Medical Care established by the Board of Trustees and headed by Dr. Orr, the immediate past president of the Association.

In addition, the House asked state and county medical societies to make greater use of A. M. A. recruitment materials in presenting medicine's story to the nation's high schools; expressed grave concern over the indiscriminate use of contact lenses; approved a Board of Trustees request to the Postmaster General for a stamp commemorating the Mayo Brothers; decided that the establishment of a home for aged and retired physicians is not warranted at this time; requested the Board of Trustees to initiate a study of present policy regarding the required content and method of preparing hospital records; and urged individual members of the Association to take a greater interest and more active part in public affairs on all levels.

As previously determined, the 1961 annual meeting will take place in New York City and the 1962 annual meeting in Chicago. At the Miami Beach meeting the House approved the following schedule for annual meetings thereafter: Atlantic City, 1963; San Francisco, 1964, and New York City, 1965.

Respectfully submitted,
Reuben B. Chrisman Jr., M.D.,
Chairman
Burns A. Dobbins Jr., M.D.
Francis T. Holland, M.D.
Meredith Mallory, M.D.

The next meeting of the American Medical Association will be in Washington, D. C., where the Clinical Session is being held November 28 to December 2.

Postgraduate Courses

With the rapid growth of Florida as a state, the rapidly expanding hospital services, the establishment of two medical schools and the competitive atmosphere of intern and resident training, postgraduate training in Florida is rapidly coming of age. For this reason certain mechanical aids will be necessary in order to avoid division of interest, duplication and waste, to secure vital information necessary for the proper programming of the lectures and wider utilization of the presence of lecturers who may be in the state. In order to accomplish this end the Committee on Postgraduate Education of the Florida Medical Association has set for itself a number of objectives which it considers desirable.

Among these objectives is the establishment of a registry for postgraduate courses to be held in the state. This registry is to have two divisions. First, a registry of courses projected, either established or in the planning stage, is proposed. The Committee desires that these courses be listed with the Florida Medical Association registry and that the information furnished include the date, duration, location, type of material and group to which the course is to be directed. Any formal educational credits that may be obtained through attendance should also be listed. It would be well to add a short biographical sketch of the various lecturers. This registry, if widely used, would prevent conflict of dates and duplication of material, and would allow the Florida Medical Association to assist in the publicity. Other organizations in the process of planning courses would be able to correlate their activities and perhaps visiting lecturers could be utilized in common.

The second portion of the registry will be composed of a dead file of past courses. Following any postgraduate course, a record of the course could be furnished to the registry. This should include the attendance, criticisms concerning the material and the manner of presentation together with an estimate of the time of year and the choice of location. This file could then serve as a reference for persons planning courses.

The Committee believes that these two files will have an immediate as well as increasing value as years go on. If they are to be effective, they must be supported by the medical population of the state, and their value will be in direct proportion to the detail in the information furnished. As a beginning, in order to secure this cooperation, the county medical societies are being circularized as well as are various other organizations which might be contemplating postgraduate courses.

The members of the Association are urged to send in material, to utilize the services of this Committee file, and to give the Committee the benefit of any criticisms or suggestions they may have.

James L. Borland, M.D., Chairman
Committee on
Postgraduate Education

Anesthesiologists Holding Annual Fall Meeting Sept. 17-18 in Sarasota

The annual fall meeting of the Florida Society of Anesthesiologists will be held September 17-18 at the Colony Beach Club Resort at Sarasota. The scientific program featuring an address by Dr. Jay J. Jacoby of Milwaukee, Wis., Professor and Chairman of the Department of Anesthesia, Marquette University School of Medicine, has been arranged by Dr. Marjorie L. Warner of Bradenton, program chairman. Dr. George H. Mix of Lakeland, vice president of the Society, will preside in the absence of Dr. Richard S. Hodes of Tampa, president.

Dr. J. Gerard Converse of Miami, Professor and Chairman of the Department of Anesthesia, University of Miami School of Medicine, will present two papers from his Department in cooperation with other faculty members. The first of these, "Anesthesia and the Asthmatic," will be given by Dr. Margaret Smotrilla, or Dr. Converse, and the second, "The Effects of Vanillic Diethylamide on Thiopental-Induced Ventilatory Depression," by Dr. Sanford Cobb or Dr. Converse.

Dr. Joachim S. Gravenstein of Gainesville, Associate Professor of Surgery and Chief of Anesthesia, College of Medicine, University of Florida, will likewise present two papers from his department. All four papers will be discussed by Dr. Jacoby in addition to his own presentation.

The two day meeting also will feature a full social program including buffet lunch, a cocktail hour and dinner—all designed to fit into the informal atmosphere of the Club which is located on Longboat Key.

109th Annual Meeting
American Medical Association
Miami Beach, June 13-17, 1960

Report of Delegates

The first Annual Meeting of the American Medical Association ever to be held in Florida attracted thousands of physicians from throughout the nation during the week of June 13-17, 1960. On this auspicious occasion approximately 10,000 doctors, their wives, medical students, nurses and exhibitors enjoyed the hospitality of Miami Beach, the host city, making a total of 20,000 in attendance. Joining with the Dade County Medical Association and the Florida Medical Association in dispensing the traditional hospitality of this famous vacation center were the medical associations of the Southeastern States. While this was the first Annual Meeting to take place within the state, the 1954 Clinical Meeting was held in Miami in 1954.

At the opening session of the 209 member House of Delegates on June 13, Dr. Louis M. Orr of Orlando, retiring President, delivered a stirring address in which he reported on his year of service in the A. M. A.'s highest office. Dr. Orr, concluding a highly successful term, had the distinction of being the first member of the Florida Medical Association ever to fill this exalted post. In his final report he urged medical societies to "adopt" rural villages, cities and regions in underdeveloped parts of the world and to send them medical, clinical and hospital supplies.

Succeeding Dr. Orr was Dr. E. Vincent Askey of Los Angeles, who was installed as the 114th President at impressive ceremonies on Tuesday night, June 14. In his inaugural address Dr. Askey declared that medicine faces its greatest challenge in the next decade and warned his fellow physicians that they must prove that medicine practiced in a free society is the most effective medicine. "It is ironic," he commented, "that at the very moment our capacity for individualized treatment is heralding a revolution in medical care, the pressures mount heavier to force us into adoption of assembly line methods." At the Wednesday session of the House of Delegates he urged intensified, accelerated effort in five areas—medical education, preparations for the White House Conference on Aging next January, health insurance and third party relationships, mental health, and membership relations.

Dr. Leonard W. Larson of Bismark, N. D., immediate past chairman of the A. M. A. Board of Trustees and of the A. M. A. Commission on Medical Care Plans, was named President-Elect by unanimous vote. Dr. Larson will succeed Dr. Askey as President at the June 1961 annual meeting in New York City.

Dr. John S. Millis (Ph.D.), President of Western Reserve University, Cleveland, Ohio, was the guest speaker at the inaugural ceremonies. In his address on "Responsibility in a Changing World" he said that the human dilemma of the sixties is an increasing desire for security and authority with a diminishing desire for responsibility. "The Amercian Medical Association," he concluded, "has a long and illustrious past because it has historically assumed the responsibilities of the past. It will retain its position as it meets the responsibility of leadership in the present."

Also at the inaugural, the 1960 recipient of the American Medical Association's Distinguished Service Award, one of medicine's highest honors, was presented the award. Dr. Charles A. Doan, who will retire next year as Dean of the Ohio State University College of Medicine and Director of the Health Center in Columbus, Ohio, was accorded this honor for his outstanding work in the field of hematology. At an earlier session, Dr. Richard W. Vilter received the 1960 Joseph Goldberger Award in Nutrition. Dr. Vilter is Professor of Medicine and Director of the Department of Internal Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio.

Among the major subjects involved in policy actions by the House of Delegates were health care for the aged, pharmaceutical issues, occupational health programs, relations with allied health groups and relations with the National Foundation.

Health Care for the Aged

The House adopted the following official policy statement on health care for the aged:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the com-

munity, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

The House also urged the Board of Trustees "to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health service and facilities needed by the aged, and that thereafter the American Medical Association present its findings and positive principles to the people."

In connection with an educational program regarding the aged, the Florida delegation introduced and the House concurred that "the American Medical Asociation increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride." At the opening session, Dr. Orr had asked the House to go on record favoring more jobs for the aged, voluntary retirement and a campaign against discrimination because of age, whether it be 40 or 65. The House also gave wholehearted approval to Dr. Askey's appeal to state medical societies to take an active part in state conferences and other planning activities preceding the January 1961 White House Conference on Aging.

Pharmaceutical Issues

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filing of drug prescriptions is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient. It pointed out that this process destroys the direct personal relationship of patient-physician-pharmacist at the community level which is essential to the public health and the welfare of patients.

The Board of Trustees was directed by the House to request the Council on Drugs and other appropriate A. M. A. councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June, 1961."

Occupational Health Program

The House approved a revision of the June 1957 statement on the "Scope, Objectives and Functions of Occupational Health Programs." The new statement contains no fundamental alterations in policy or ethical relationships, but it adds important new material on: (1) greater emphasis on the preventive and health maintenance concepts of occupational health programs; (2) a more positive statement of organized medicine's obligation to provide leadership in improving occupational health services by part time physicians in small industry; (3) increased emphasis on rehabilitation of the occupationally ill and injured; (4) inclusion of the proper use of immunization procedures for employes, as approved by the House in 1959; and (5) a more adequate statement on the need for teamwork with lay industrial hygienists in tailoring each occupational health program to the particular employe group involved.

Also accepted by the House was a suggestion that the A. M. A. Council on Occupational Health undertake a project to study and encourage the employment of the physically handicapped.

Allied Health Groups

Commending it as "a monumental work," the House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services. The report covers the present situation, future implications and recommendations, including guiding principles and approaches to activate physician leadership. The House strongly recommended that A. M. A. activity in this vitally important area be continued and it approved the appointment of a Board of Trustees committee to carry on the work.



Dr. Samuel P. Newman, Chairman of the Medical Advisory Board of the Sears-Roebuck Foundation, presents a citation to Dr. Orr for his services and contributions to organized medicine during the past year.

medical profession. It was conferred on Dr. Orr on this initial occasion for his meritorious service, exemplary leadership and selfless devotion to his task.

Dr. Orr has indeed been an able spokesman for the medical profession and has served with great distinction at home and abroad—from coast to coast across his own nation, in Europe, in Africa, in South America, and in recent weeks in the Far East—Tokyo, Bangkok, Hong Kong and Manila. His travels convinced him that an aspirin tablet or a bandage to help ease the pain of lepers could produce more good will in some remote outposts of the world than dollars or diplomacy. He therefore proposed a kind of people-to-people aid by county, metropolitan, and even state medical societies whereby they would adopt a rural village, a city or a region on another continent with the sole purpose of helping to improve the health of the people and the area. This aid could include all sorts of medical, clinical and hospital supplies—medicine, instruments, utensils,



Dr. Orr congratulates Dr. E. Vincent Askey, of Los Angeles, incoming President of the American Medical Association.



Dr. Orr, retiring President of the American Medical Association, receives the congratulations of Dr. Homer L. Pearson Jr. of Miami (left), co-chairman of arrangements for the annual meeting, and Dr. Mortimer Sackler, Chairman of the Board of The Purdue—Frederick Company, after Dr. Orr was given "The Purdue—Frederick—American Medical Association Presidential Award," a sculptured clear crystal vase.

equipment, bandages, books and beds—and it might even include the services of a member-physician for a period of time. "Our goal," he said, "would be the control of tuberculosis, cholera, malaria, leprosy, typhoid, hepatitis, dysentery, internal parasites and the other prevalent diseases so that suffering might be alleviated, death postponed and healthful living promoted. I believe that this great challenge compels us to act. . . .With the medical societies, their members, their Woman's Auxiliaries, and the new A. M. A. department of international health working together, I believe that American medicine can make a significant contribution to the health improvement of the people in newly developing nations."

"In the majority of areas," Dr. Orr commented in his farewell remarks as the 113th President of the American Medical Association, "I have found physicians holding firm and united in their belief that good medicine must have freedom in which to grow. I have found physicians dedicated to the task of helping humanity to ever better health and longer life either through active practice, or through scientific research or teaching. For me, this has been a rich and rewarding experience . . . to know the cooperation of the members of our profession, and to feel the strength of their unity to the heritage of medicine. At the same time, I have found that the price of progress can only be continuing observance of those standards in medical affairs which lead our moral conduct, our community activities, and our political endeavors toward the sound, long range goal of ever increasing advances in medical care for everyone. Knowing that these standards have brought us to our present peak of achievement, we can continue to face our problems with confidence and strength."



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OTHERS ARE SAYING

Principles of Prophylaxis Against Tetanus

1. Thorough cleansing and débridement of wounds, at times leaving the wound open, are the most important parts of prophylaxis against tetanus.

2. The need for and method of prophylaxis against tetanus must be determined for each patient according to individual indications. It cannot be standardized.

3. The skin and eye tests for sensitivity to horse serum and a carefully taken history of possible allergic manifestations are a medical responsibility. Before giving tetanus antitoxin to a patient, the physicians must determine whether the danger of tetanus exceeds the danger of anaphylaxis.

4. Passive immunity with tetanus antitoxin is short-lived, but the greater the dosage of tetanus antitoxin, the longer the duration. In the opinion of the majority of this subcommittee (see box) 1,500 units of tetanus antitoxin are of limited and transitory value and are inadequate dosage; if tetanus antitoxin is really indicated, the dosage should be a minimum of 5,000 units. Tetanus can develop even with passive immunity, particularly after the first week.

5. The patient who has had horse serum previously may neutralize a new injection rapidly even without a positive skin or eye test. The patient sensitive to horse serum is extremely likely to neutralize it rapidly. A patient may be sensitive to horse serum without having received an injection of horse serum previously.

6. Routine use of alum precipitated toxoid appears advisable for basic immunization and booster injections. Fluid toxoid may be used as a booster injection, but not when simultaneous passive-active immunization is being provided. Authorities are not in full agreement as to the advantages and disadvantages of each type of toxoid.

7. The production of tetanus toxin within the tissues following a wound in an actively immunized individual probably stimulates a rise in titer of antibodies, yet the rise may not be rapid enough to protect; hence, routine booster injections every two to four years and a "wound booster" are advised.

8. Penicillin and broad spectrum antibiotics initiated promptly after injury are probably powerful deterrents against tetanus infection, especially for a brief period. Tetanus is a toxemia and not an invasive infection. Even so, evidence is available that antibiotics given early are valuable in preventing the infection. Antibiotics should not be used as a substitute for active or passive immunization.

9. Every patient with a severe wound, whether immunized passively or actively, should be watched closely for several weeks for signs of local tetanus, which precede systemic signs in the great majority of instances.

10. Studies indicate that individuals who have once had basic immunization with tetanus toxoid may have an adequate level of protection recalled by a booster dose no matter how many years have elapsed since the course of basic immunization or the last booster dose.

11. The Board of Regents and the Committee on Trauma, of the American College of Surgeons, recommend that mass immunization with tetanus toxoid be a part of every program for civil defense.

Basic Immunization

1. Primary active immunity is obtained by giving three doses of the alum precipitated toxoid subcutaneously. The second dose is given one month after the first; the third dose, six to 12 months later. Periodic booster doses are then given normally at intervals of four years.

2. Infants and children up to four years of age receive tetanus toxoid in combination with diphtheria toxoid and pertussis vaccine. This is given at monthly intervals for three doses with a fourth dose one year later. Children four to 11 years of age are given the tetanus-diphtheria toxoids. (These combinations are used for booster doses as well as basic immunization.)

3. For other patients likely to incur tetanus-prone wounds whom the physician regards as in particular need of highly effective tetanus im-

Statements by Committee

THIS STATEMENT on prophylaxis against tetanus has been prepared by the Committee on Trauma's Subcommittee on Prophylaxis Against Tetanus. The subcommittee, including advisory members, is composed of Drs. Oscar P. Hampton, Jr., St. Louis, chairman, William A. Altemeier, Cincinnati, Geoffrey Edsall, Washington, Stanley F. Hampton, St. Louis, Howard E. Snyder, Winfield, Kansas, and Edward S. Stafford, Baltimore. The members of this subcommittee are not in full agreement on some of the details discussed herein, but they are in full agreement on the principles involved. This report will be in part of the second edition of the manual *Early Care of Acute Soft Tissue Injuries* (page 117).

munization, including the maintenance of an adequate antitoxin level for the control of unrecognized infections, the administration of four doses of toxoid in the primary immunization schedule and period booster doses at intervals of two years, will serve the purpose.

Tetanus Prophylaxis In Wound Management

1. Patients previously immunized (active) with toxoid—

a) To individuals who have had their basic immunization or a booster dose of tetanus toxoid within four years, give 0.5 milliliter of alum precipitated or fluid toxoid subcutaneously.

b) For individuals who have had basic immunization but have not had a booster dose within four years of the time of a wound, a booster dose of toxoid is all that is usually required. However, when the character of the wound indicates an overwhelming possibility of tetanus infection, additional protection, particularly for the first few days, should be given, provided the individual is not sensitive to horse serum. Five thousand units of tetanus antitoxin are given in one arm, while with a separate syringe and needle, 0.5 milliliter of *alum precipitated* tetanus toxoid is given in the other arm as a wound booster.

2. Patients not previously immunized with toxoid—

a) In individuals with clean minor wounds for which passive immunization is not provided, active immunization with alum precipitated toxoid should be initiated. This opportunity to start active immunization should not be wasted.

b) To individuals who have never been immunized with toxoid, but in whom the character of the wound indicates the need for tetanus prophylaxis, give 5,000 units of tetanus antitoxin (Item 3, Determination of Sensitivity to Equine or Bovine Serum). At the same time initiate active immunity against tetanus by giving 0.5 milliliter of the alum precipitated tetanus toxoid in a different extremity with a separate syringe and needle. Urge the patient to complete the series of injections so as to obtain active immunization.

c) In individuals sensitive to horse serum (Item 3-a, on history of sensitivity to horse dander or serum, or positive skin and eye tests), a careful history to elicit possibility of sensitivity to beef products should be taken and tests for sensitivity to bovine tetanus antitoxin should be carried out. If the patient is found not sensitive to bovine serum, give 5,000 units of bovine antitoxin.

d) If the patient has a positive or suspect history, or positive or suspect sensitivity test, administer 0.1 milliliter of 1:10 dilution of antitoxin subcutaneously, having adrenalin in a syringe, ready to use, at hand. If no significant reaction is observed in 30 minutes, administer 0.1 milliliter of undiluted antitoxin subcutaneously. If no reaction of significance occurs during the following 30 minutes, the remainder of the dose may be given subcutaneously or intramuscularly.

e) If there is a clear-cut history of severe reactions to both equine and bovine serum, or if a reaction occurs with the tolerance test outlined in *d* above, do not give antitoxin. Human hyperimmune globulin may be given if available. If not, in urgent cases consideration is given to the use of transfused blood from a donor who has received a booster dose of tetanus toxoid one month previously. Insure adequate débridement of the wounds and leave them open. Give penicillin or tetracycline derivatives promptly in large doses for the estimated incubation period of tetanus (a minimum of 10 days). In all instances start basic, active immunization with alum precipitated tetanus toxid.

3. Determination of Sensitivity to Equine or Bovine Serum. Prior to the administration of any animal serum, all patients should be carefully examined for possible sensitivity to that serum. Such examination includes:

a) History. Question the patient carefully concerning allergic conditions, especially asthma, eczema or urticaria, past or present. Previous injections of horse or other serums of any kind may be significant, particularly if a reaction ensued. Sensitivity frequently develops after the first injection of animal serum. A known sensitivity to horse dander is a danger signal, as is sensitivity to beef products.

b) Skin Tests. Inject 0.02 to 0.03 milliliter intracutaneously of a 1:10 saline dilution of tetanus antitoxin. The area of infiltration should be about the size of the head of a pin. A positive reaction in 15 minutes or less, manifested by a hive-like wheal and erythema, indicates sensitivity to the horse serum. The larger the wheal, the greater the sensitivity. A wheal up

partment of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville; Dr. Warren W. Quillian, Coral Gables pediatrician and Professor of Clinical Pediatrics, University of Miami School of Medicine; and Dr. Luella M. Klein, Obstetrical Consultant, Georgia State Department of Public Health, Atlanta, and Instructor in Obstetrics and Gynecology, Emory University School of Medicine.

As usual, there will be no registration fee, thanks to a special grant from the U. S. Children's Bureau. Physicians are urged to make their reservations at Ellinor Village as soon as possible.

Postgraduate Medical Seminar Cruise October 12-23, 1960 Sponsored by The University of Florida College of Medicine

A medical seminar has been arranged aboard the SS Hanseatic during a 10 day Caribbean Cruise. On each of the five and a half days aboard ship there will be a medical program consisting of seminars, informal conferences, and clinicopathological discussions with material designed to be of particular benefit to physicians in general practice. Round table conferences will be conducted during the evenings of those days when the ship is in port.

The subject matter to be presented will be selected from the fields of pediatrics, gynecology, orthopedics, medicine and surgery by a faculty from the University of Florida College of Medicine. Facilities aboard the 30,000 ton SS Hanseatic are excellent, and this seminar cruise will provide unique opportunities for informal discussion of medical problems with fellow registrants and with the faculty.

Ports to be visited include St. Thomas, Martinique, Barbados, Curacao and Port-au-Prince. A 20 minute color film demonstrating ship facilities is available upon request. For further information, write to the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

The Eighty-Seventh Annual Meeting of the Florida Medical Association is scheduled for Thursday, Friday, Saturday and Sunday, May 25-28, 1961. It is being held in the Americana Hotel at Bal Harbour north of Miami Beach where the Association met in 1959.

PHYSICIAN'S HOBBIES

Jazz Is My Hobby

Why is Jazz my hobby? Why do I like Jazz? Why should you as a physician consider Jazz as a hobby? A glance at the word Jazz shows that it has the first and last letter of the alphabet, and sure enough, Jazz music for anyone interested in music has everything from A to Z.

All of us are busy doctors—putting in countless hours in the care of our patients. All of us have to earn a living to meet the cost of our practices and to provide for our families. During the 24 hour day, not only must we work, but also must find the time to share the task of being a father and husband, meeting the responsibility that goes with it. As a result, we, too, as human beings must partake of the same advice we give to our patients, namely, to rest and relax after a hard day of work. Many find relaxation in fishing, others in stamp or coin collecting, others in painting or woodworking. All of us should have a hobby—but alas only too few, I would sadly venture, make a hobby out of something in which we find great enjoyment and pleasure.

Jazz music has been for me a great source of contentment. It has made many friends and new acquaintances. At times it has been a form of medical therapeutics. As a boy, reared in the large city of Chicago during a turbulent era of the so-called roaring and lawless twenties, it was my happy experience to be personally acquainted with the "dives" and "joints" so prevalent in those days which for many a Jazz musician was his home. My interest in Jazz began when as a boy my cousins would invite me to go along to a Saturday night jam session. It was at these sessions that the Jazz artist would really open up and play his heart out for his friends and relatives. The Jazz artist has his own way of conveying a message, whether it be during a blue mood or a happy one. His feeling would be imparted to his audience —creating enjoyment and gratification. Thus a psychological need was fulfilled, depending on the mood at that particular time. It was only natural, therefore, that I should find in Jazz music that something which for me met the bill, just as fishing does for others.

Jazz is a versatile form of music. While Jazz has a basic form, the expression of that form by a Jazz musician playing a musical instrument can



Dr. Lombardo's hobby as shown at the Annual Meeting of the Florida Medical Association in Jacksonville.

be so improvised as to meet the musician's particular mood at that particular moment, and so he in turn imparts to the listeners a similar personal experience. Since, however, Jazz music has various musical expressions, I can pick the music to meet my personal satisfaction, to fit my mood at that particular moment. For me, Jazz music has been a source of constant personal gratification. Many times, after a hard day at the office, listening to a stack of Jazz records has driven away the problems of the day, preparing me for a night of restful sleep. Jazz as a hobby has brought much pleasure. Listening to a Jazz artist and band perform in front of an enthusiastic audience is an unforgettable experience, and then the buying of a record by that artist or band, taking it home, playing it on the turntable and sitting down in a comfortable chair is reliving that experience. Each time the record is played, that same old feeling is there again to repeat the satisfying pleasure once more.

For those of you who are interested in music I suggest that you try Jazz. I feel you would find that Jazz music, whether it be in the form of the blues, or traditional, modern or cool, will be for you rewarding and illuminating. Its music will bring peace and comfort to many a wearisome day. At times Jazz music will be inspirational as well. Jazz has no human boundaries; it has an appeal all its own, for the highbrow and the lowbrow. Once you become acquainted with it, you will find that while it may not be the ultimate in fine living, it will be the ultimate for many hours of pleasant relaxation. So for those of you who do not have a hobby, may I suggest you consider Jazz, and for those who already have a hobby and would like to venture into a new one—try Jazz. You may find a new source of pleasure you had not anticipated.

Samuel S. Lombardo, M.D.
Jacksonville

Note: This is the first in a series of discussions of various hobbies being enjoyed by physicians in Florida. These articles are published in the hope that those physicians who do not have a hobby might be encouraged to begin one, and for those who do have a hobby, these remarks may be a source of interest. The Committee on Scientific Work would like to know about your hobby for possible display at the next Annual Meeting. The blank published in this issue of The Journal on page 188 is for your convenience.

Florida Physicians Among Nationally-Known Speakers At Florida Academy of General Practice Assembly Jacksonville, October 21-22

Dr. James G. Lyerly of Jacksonville will appear on the scientific program of the Eleventh Annual Scientific Assembly of the Florida Academy of General Practice, to be held in Jacksonville on October 21 and 22, 1960. A second Florida physician, Dr. Peter F. Regan, Professor and Head of the Department of Psychiatry, University of Florida College of Medicine, will present a paper within his field of particular interest to general practitioners.

Dr. Lyerly will discuss "Strokes, Subdural Hematoma and Brain Tumor," and within the same field, Dr. Temple Fay of Philadalphia will present two papers, "Practical Considerations in Diagnostic Screening of Cerebral Accidents and Chronic Types of Paralysis" and "Cerebral Hydrodynamics and Important Recent Clinical Tests for Establishing a Diagnosis in Neuro-Muscular Disorders."

Dr. Regan will join with Dr. T. A. Watters of New Orleans to cover aspects of Psychiatry in general practice. Dr. Regan will present "The Uses of Psychopharmacological Agents," and Dr. Watters, known for his work in training general physicians in Psychiatry, will discuss "Basic Concepts in Teaching Non-Psychiatric Physicians Management of Psychiatric Problems" and "The Application of Psychiatric Principles in General Practice."

Dr. Joseph R. Shaeffer of San Antonio, Texas, will talk on "Disaster Medicine—An Integral Part of the National Defense Effort." Many Florida doctors will remember Dr. Shaeffer's memorable appearance on the Academy's program in 1958, and on the program of the American Academy of General Practice Annual Scientific Assembly in Philadelphia earlier this year. "Allergy of the Respiratory Tract—Diagnosis and Treatment" will be presented by Dr. Leon Unger of Chicago.

Dr. R. R. Killinger of Jacksonville, General Chairman of the Assembly Committee, announced that final arrangements for an excellent exhibit hall, housing and dining, entertainment and ladies program are being completed, and that a larger enrollment is expected this year than for any previous meeting. All physicians are cordially invited to attend the scientific sessions and other activities of the meeting. There will be a meeting of the Academy's Board of Directors, to which all Academy members are invited, and a general business meeting. Particular attention is being given to the cocktail hour, dinner party and ladies' activities. Category I credit will be assigned to the scientific sessions, and all Academy members are urged to make this meeting a "must" on their calendars.

The Eleventh Annual Scientific Assembly will be held at the Hotel Robert Meyer, Jacksonville, October 21 and 22, 1960.



Dr. Lyerly



Dr. Regan

Correction

On page 53 of the July issue of The Journal, Dr. George S. Palmer of Tallahassee was incorrectly identified under his picture as Mr. Palmer. For this mistake, the Journal extends sincere apologies to Dr. Palmer.

Postgraduate Seminar On Fractures September 22-24, 1960 College of Medicine, Gainesville

The two day Seminar in Orthopedic Surgery, sponsored by the University of Florida College of Medicine, will consist of panel discussions of fractures commonly seen in clinical practice. These include fractures of the foot, ankle, leg, knee, thigh, hip, hand, wrist, forearm and elbow, and a panel on prevention and care of athletic injuries. Topics are to be discussed informally by the case presentation method, and all discussors will comment on each case. Demonstration of techniques in manipulation and plaster application will also be held. Attendance at the Seminar will be limited to 20 participants in order that discussions may be held on an informal, teaching conference basis.

Instructors are W. F. Enneking, M.D., Associate Professor of Surgery and Chief of Orthopedic Surgery, and N. R. Greville, M.D., Assistant Professor of Surgery, University of Florida College of Medicine; Hugh Haston, M.D., Jacksonville; and Paul Wallace, M.D., St. Petersburg.

Group tickets have been reserved for the U. of F.—F. S. U. football game on Saturday, September 24. A detailed program has been mailed to physicians. Applications for this Seminar should be mailed to the Division of Postgraduate Education, University of Florida College of Medicine, Gainesville, accompanied by a registration fee of $25.

Awards to First Graduates College of Medicine University of Florida

Special awards went to three members of the first class of physicians ever trained at the University of Florida. Prior to commencement ceremonies on June 6, 1960, the Class of 1960 hosted a banquet at the Gainesville Golf and Country Club for the presentation of awards to faculty and the receipt of others by graduating seniors.

Roger F. Palmer of Clearwater, who, incidentally, graduated with honors, received the Faculty Research Award. He was selected by the Executive Committee of the Faculty of the College of Medicine for extremely high caliber research conducted during his four years as a medical student.

Brunildo A. Herrero of Miami received the John Gorrie Award, donated by Dr. Theodore F. Hahn of Deland. Also selected by the Faculty Executive Committee, the graduating senior who shows promise of becoming a practitioner of the highest type will receive the award annually.

Mrs. Jean Lester Bennett of Dunedin received an honorable mention citation from the American Women's Medical Association for scholastic achievement.

Students presented awards to two faculty members. Dr. Jape Taylor, Assistant Professor of Medicine, was selected by the class as the outstanding instructor in clinical medicine, and Dr. Donald Goodman, Associate Professor of Anatomy, received the Class' award as the outstanding instructor in the basic sciences.

The Class of 1960 also presented Dr. George T. Harrell, Dean of the College of Medicine, with an engraved wrist watch, and his assistant, Mrs. Jo Potter, with a sterling silver bowl. In addition, the class voted a small sum of money to be left behind for small unrestricted student loans for medical students.

Tenth Annual Postgraduate Obstetric-Pediatric Seminar Daytona Beach, August 18-20

For the tenth successive year the State Health Departments of Florida, Georgia, South Carolina and Alabama, and the Florida Academy of General Practice will sponsor a Postgraduate Obstetric-Pediatric Seminar. As last year, the meeting will be held at the Ellinor Village Country Club, Daytona Beach, on Thursday, Friday and Saturday, August 18, 19 and 20, 1960.

The high caliber faculty which has typified this Seminar is again assured. Among those scheduled to address physicians attending the meeting are Dr. Robert A. Ross, Department of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill; Dr. Frank A. Finnerty Jr., Assistant Professor of Medicine and Pharmacology, Georgetown University Hospital, Washington, D. C.; Dr. Edward J. B. Dennis, Medical College of South Carolina, Charleston, and chairman of the Maternal Health Committee of South Carolina; Dr. Mildred T. Stahlman, Department of Pediatrics, Vanderbilt University School of Medicine, Nashville. Tenn.; Dr. Gerard B. Odell, Assistant Professor of Pediatrics, The Johns Hopkins Hospital, Baltimore; Dr. Harry Prystowsky, Professor and Head, De-

to 0.5 centimeter in diameter, or approximately the size of the rubber end of a pencil, may be a nonspecific positive reaction which may be confirmed by a control skin test with normal saline. If the control test appears the same as the serum test, the reaction with tetanus antitoxin may be considered negative.

c) Eye Tests. Place a drop of 1:10 dilution of tetanus antitoxin in the conjunctival sac of one eye at the time the skin test is made. Redness of the conjunctiva, occurring in five or 10 minutes, indicates a positive reaction. If the test with 1:10 dilution is negative and the skin test is positive, the eye test should be repeated with the concentrated tetanus antitoxin.

Bulletin of the American College of Surgeons May-June, 1960.

BLUE SHIELD

Growing Up

Constantly increasing and aggressive competition notwithstanding, Blue Shield continues to grow steadily. Today there is great public awareness of the necessity for greater protection against the expenses of illness, a trend which was sparked a quarter of a century ago by the service philosophy of the "Blues."

At the end of the first quarter of 1960 national Blue Shield enrollment had increased a net 845,319 to the quite respectable total of 45,647,242, according to the National Association of Blue Shield Plans. Blue Shield now covers nearly one fourth of the total population of the United States and almost 15 per cent of the total Canadian population.

Equally impressive is the gain in Florida. At the end of March, Blue Shield enrollment in the state had reached 821,129, a net gain of 11,015 over the total at the end of 1959. Because Blue Shield in Florida began after Blue Cross was already in operation, it has consistently showed a lower enrollment than its sister Plan. Today, that differential has been almost eliminated.

The future looks promising, but the extent of growth will be regulated by a number of factors, the effect of which are not readily determinable. First and foremost is the enthusiasm and confidence exhibited by the medical profession. Recently the appeal of Blue Shield coverage to groups, particularly to the employer, has been augmented by the addition of supplementary coverage to the basic program through Extended Benefits and Master Medical Endorsements. The latest variable is the effect the new Health Benefits Program for Federal Employees will have on enrollment. There will, of necessity, be some adjustment in figures as these employees are dropped from their present groups or individual coverage

(Continued on page 192)

SHARE YOUR HOBBY

My hobby is _____

_____

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Please reserve space for me to display it at the Annual Meeting in Miami Beach.

Signed _____

Mail to:

Thad Moseley, M.D., Chairman
Committee on Scientific Work
P. O. Box 2411, Jacksonville

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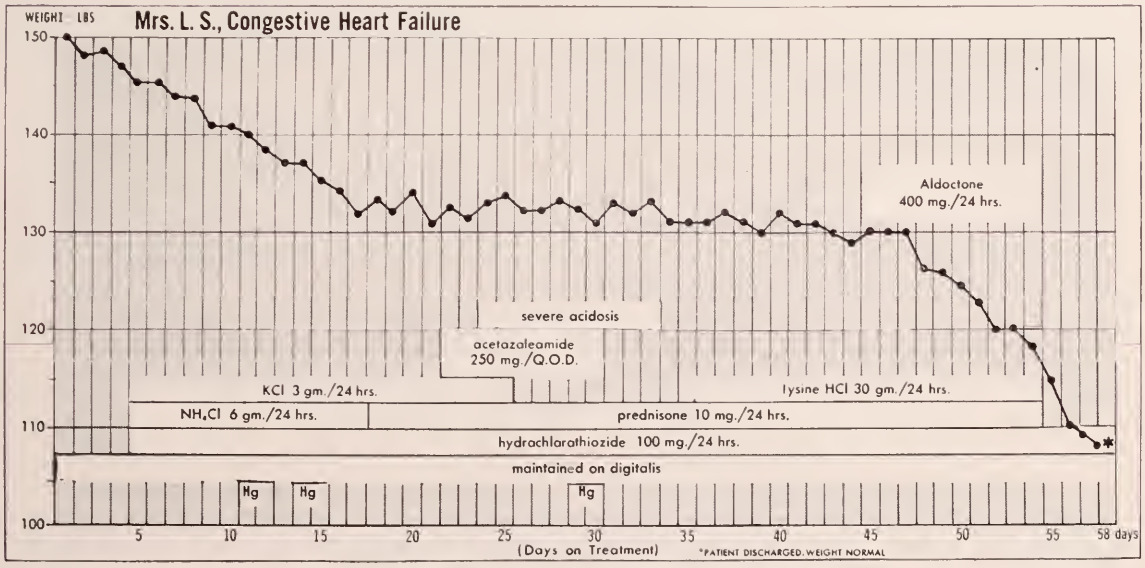
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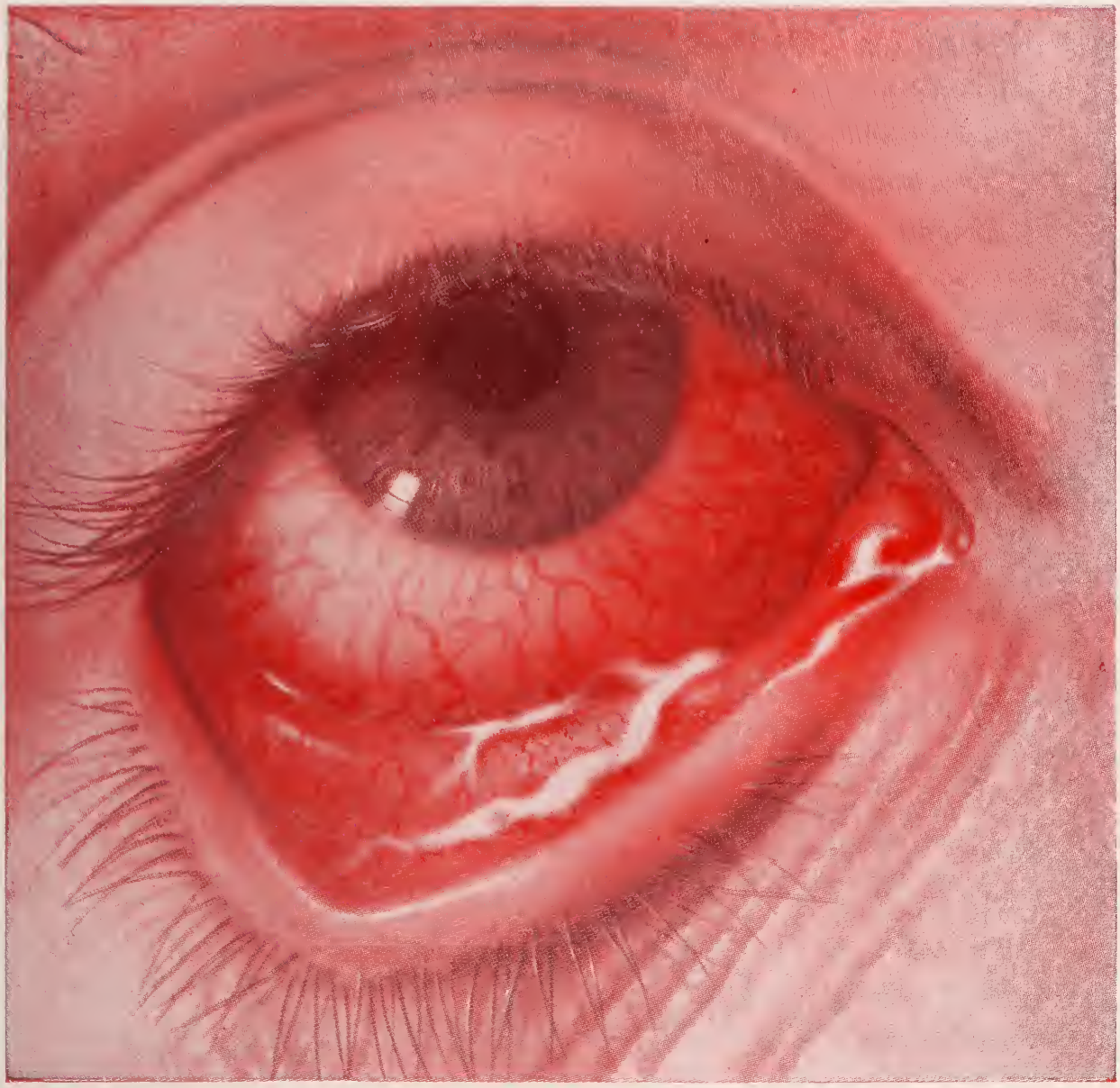
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Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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(Continued from page 188)

and transferred to the federal records. It is too early to know how many federal employees have selected the Service Benefit Plan, administered by Blue Cross and Blue Shield.

The physician must always be the key figure in any program for protection against the cost of illness. With his continued support and cooperation Blue Shield cannot fail to continue its remarkable growth.

STATE NEWS ITEMS

Drs. James L. Borland and W. Roy Hancock of Jacksonville participated in the program of the Section on Gastroenterology and Proctology of the recent annual meeting of the American Medical Association held in Miami Beach. Drs. Borland and Hancock presented a paper entitled "Intestinal Resections and Anastomoses" as part of the Symposium on Postsurgical Problems of the Gastrointestinal Tract.

Dr. Ralph W. Jack of Miami, Immediate Past President of the Florida Medical Association, by request has been participating in the Adult Education Program of the Recreation Department of the City of Miami Beach. On June 6, he presented an address entitled "American Medical Association—Guardian of the Nation's Health." On May 24, Dr. Jack was featured speaker at a meeting of the Exchange Club in Miami and presented an address on "The Medical Profession's Views on Medical Care of the Aged." Earlier in May, Dr. Jack accepted an invitation to present the annual address at the meeting of the Indianapolis Surgical Society. For this engagement, his subject was "Our Other Responsibilities." By request, he remained in Indianapolis the next day in order to speak on the same subject to the senior class of the University of Indiana School of Medicine.

Dr. Louis M. Orr of Orlando, Past President of the American Medical Association, has become an honorary member of the Pinellas County Medical Society by action of its board of governors at a meeting in May. The official resolution states that members of the Society have had great respect for Dr. Orr as a colleague of the Florida Medical Association and "that respect has been broadened to admiration and affection because of his esteemed ability in leading the medical pro-

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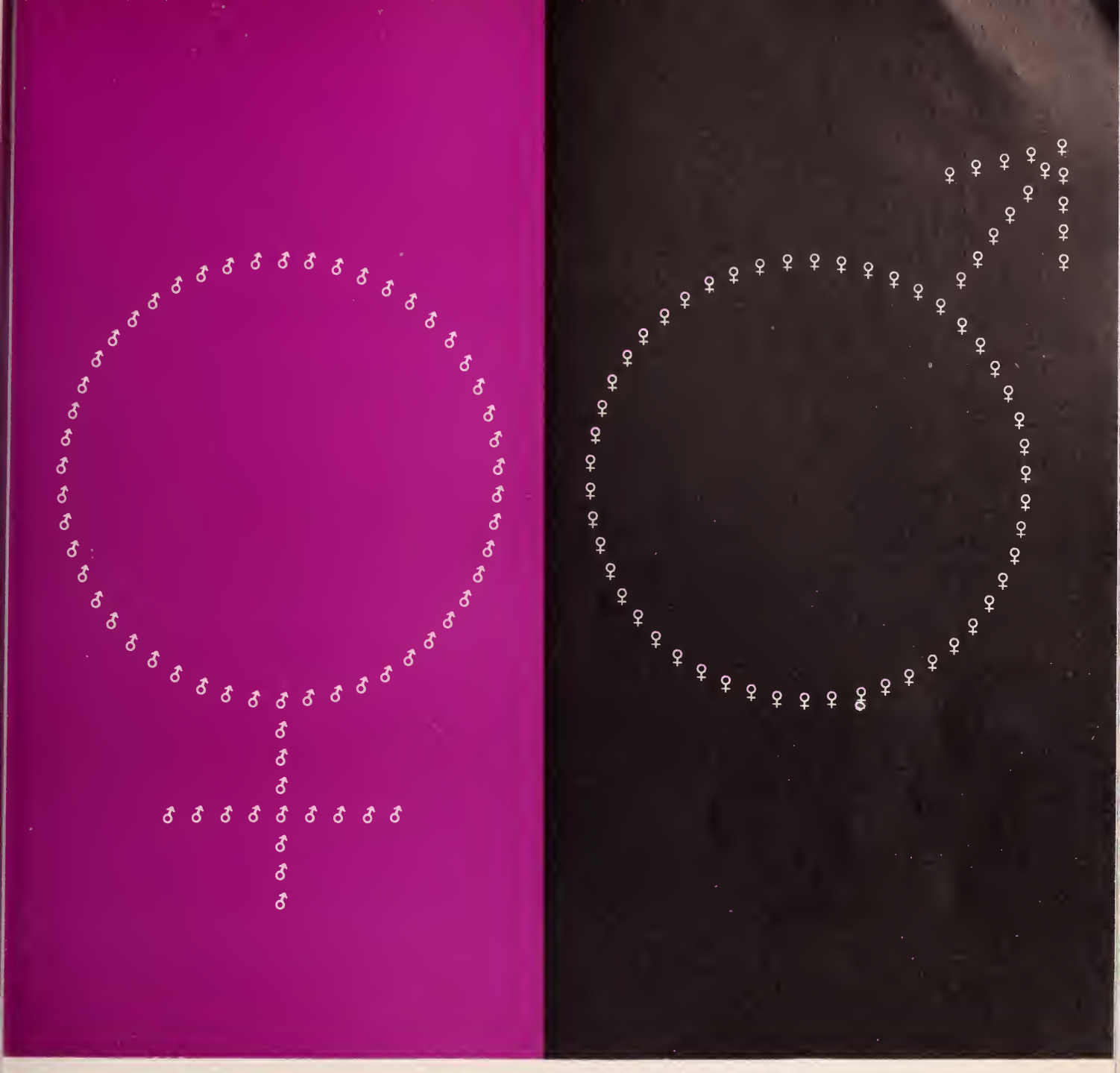
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Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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fession of our mighty nation as President of the American Medical Association," and that honorary membership is extended to him "in recognition of his excellent service to county medical societies throughout the United States."

Dr. Sanford Cobb of Miami has been elected president of the Greater Miami Society of Anesthesiologists. Serving with Dr. Cobb will be Dr. Hugh J. Forthman as vice president and Dr. Edward A. Talmage as secretary-treasurer. Drs. Forthman and Talmage are also from Miami.

Dr. Jess V. Cohn of Fort Lauderdale had two papers presented at the recent Thirty-Fifth Congress of the Pan American Medical Association held in Mexico City. The titles of the papers were "The Morbidophilic Diathesis" and "Remarks on the Dynamics of an Administrator-Led Graduate Group at Patient Conferences."

Dr. Lewis A. Shepperd of Miami Beach presented a paper entitled "Current Concepts of Adenotonsillectomy Anesthesia in Children" at the Seventh Panamerican Congress of Oto-Rhino-Laryngology and Bronchoesophagology held at Miami Beach.

Dr. Sanford A. Mullen of Jacksonville has been elected president of the Duval County Division of the Arthritis and Rheumatism Foundation succeeding Dr. Thomas S. Edwards also of Jacksonville.

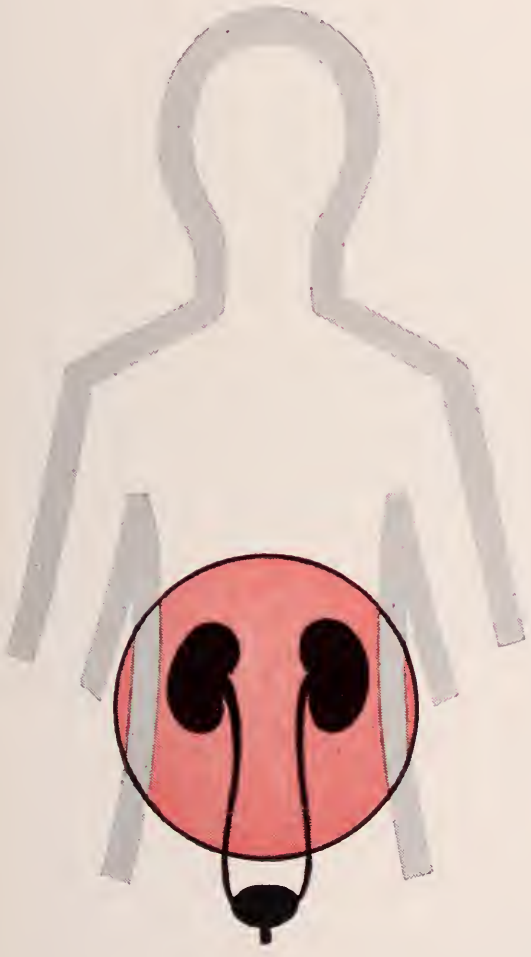
Dr. L. Roland Young of Daytona Beach has been elected to membership in the American Society of Medical Psychiatry, Inc.

Dr. Morton M. Halpern of Miami presented a paper entitled "Clinical Management of Hypertension in the Older Patient" at the 17th annual meeting of the American Geriatrics Society held June 9-10 at Miami Beach.

The College of Medicine, University of Florida, has received a grant of $40,000 from the Suncoast Heart Association in St. Petersburg. Dr. Samuel P. Martin, Professor of Medicine, will administer the grant which will support an established investigator full time in the study of heart and vascular disease.

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Dr. John B. Brinson of Monticello, who has practiced in Jefferson County for almost 50 years, was honored at a celebration there July 8-9. A new $50,000 clinic which Dr. Brinson assisted in erecting was dedicated during the event.

Dr. Richard G. Skinner of Jacksonville has been appointed a member of the committee to choose Florida's recipients of the National Foundation's 1960 health scholarships.

Dr. Ben J. Sheppard of Coral Gables has been elected judge of the Dade County Juvenile and Domestic Relations Court. Dr. Sheppard has been practicing in the Miami area for 25 years, and in addition as an attorney has been teaching in the law school at the University of Miami. He is chairman of the medical-legal committee of The Florida Bar.

Dr. Sidney Grau of St. Petersburg has been elected president of the Suncoast Heart Association. Dr. Charles H. Lasley of Clearwater has been elected second vice president, and Dr. Charles L. Rast Jr., of St. Petersburg, third vice president.

Dr. Meredith Mallory of Orlando attended the recent 45th reunion of the members of his class at the Harvard Medical School in Boston.

Dr. Clyde E. Asbury Jr. of Lakeland has been engaged in postgraduate study in internal medicine at Peter Brent Brigham Hospital in Boston.

Dr. Walter W. Sackett Jr. of Miami has been elected president of the University of Miami General Alumni Association.

Dr. John C. Patterson of Sarasota has been presented a golden anniversary diploma by Tulane University as a member of the class of 1910. Dr. Patterson was one of 59 members of the class honored during commencement ceremonies for the 1960 class. During the graduation exercises, the 50 year graduates were seated in a special section, and at noon that day, they were guests of the Tulane Alumni Association at an anniversary luncheon.

A six day short course, "Executive Development for Hospital Housekeepers," is scheduled for the University of Florida Teaching Hospital

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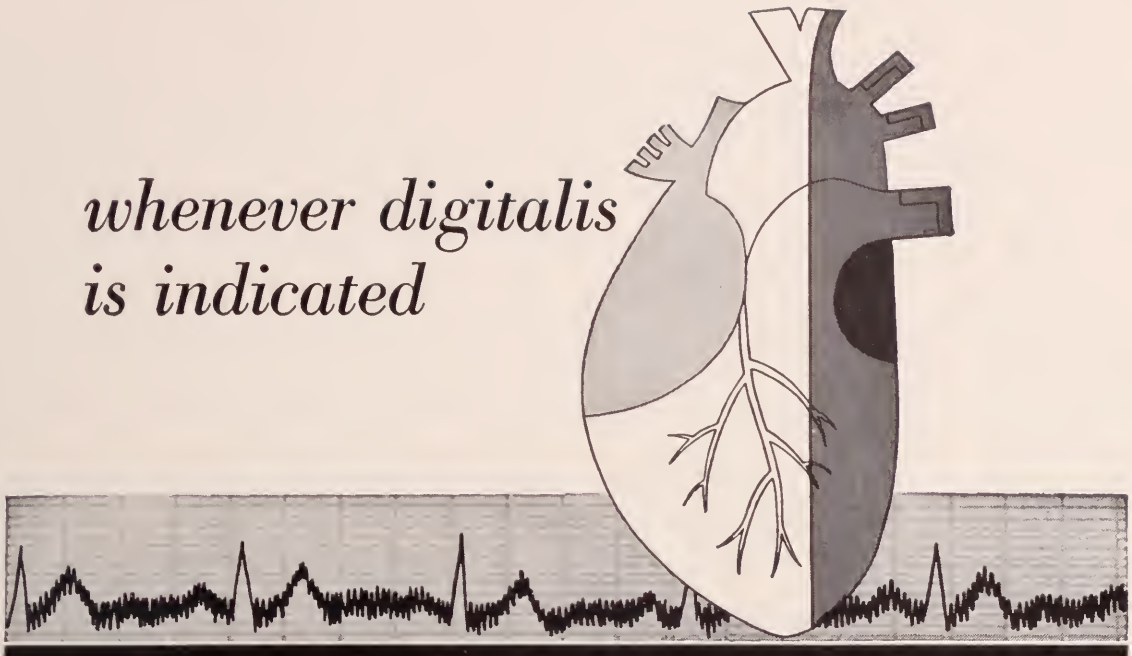
Why limit the convenience, flexibility and productivity of your examining room storage space? American Modular offers an unlimited selection of special-purpose work-and-storage units, arranged and positioned exactly where you need them for more productive, less fatiguing office hours. American Modular assemblies fit flexibly into old or new, large or small examining rooms . . . are easy to install, add-on-to, move . . . cost less than conventional instrument and treatment cabinets. For full details, contact.

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Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

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0.05 mg. in 1 cc.

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Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

VALENTINE Company, Inc.
RICHMOND 21, VIRGINIA

and Clinics October 17-22. The course is designed to assist the hospital housekeeper in developing professionally as an effective executive member of the hospital management team. Mrs. Anne J. Vestal, executive housekeeper of the Teaching Hospital and Clinics, is the supervisor of instruction.

WOMAN'S AUXILIARY

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
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Message from the President

"The Advantage of Private Medical Care" was the essay title of Tamara Townsend, Fort Lauderdale, that won for her $250. This was the third prize in the national contest sponsored by the Association of American Physicians and Surgeons' Freedom Programs. At the state level, awards were presented to Joan Rubin, Fort Pierce; Tamara Townsend, and Marietta Philpot, Pensacola.

Two new county auxiliaries have been organized during the past year, Highlands and Walton-Okaloosa-Santa Rosa. This brings the number of organized auxiliaries to 26, with a total membership of 2,427.

Future Nurses Clubs in Florida high schools now number 120. Their program has been broadened to include all medical careers. Three Future Medics Clubs have been organized to acquaint high school students with requirements and advantages of a medical career.

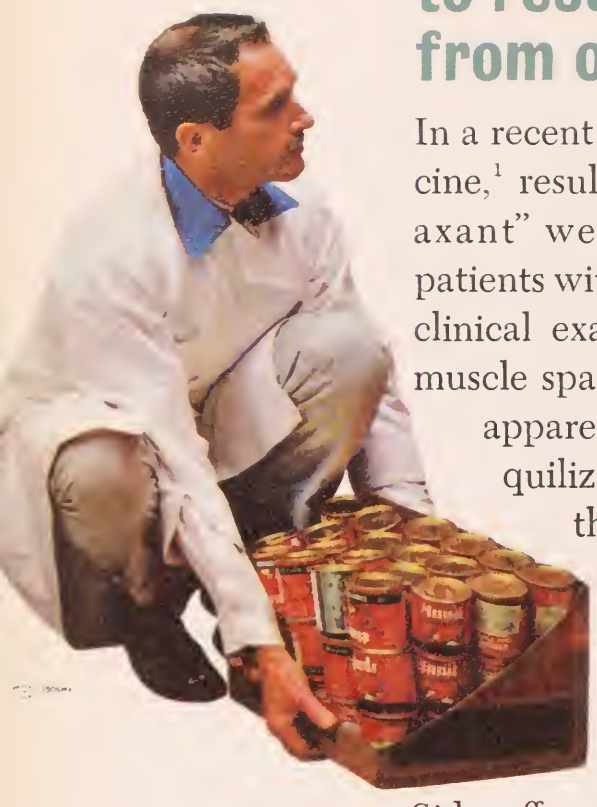
Our first activity of the new Auxiliary year was the National Convention in Miami. Many of our members from all parts of the state were privileged to assist the Dade County Auxiliary under the able leadership of Mrs. Richard F. Stover, National Convention Chairman.

The Board consists of officers, committee chairmen, and county presidents, who stand ready to assist the medical association in every way possible.

Mrs. John M. Butcher


Save a
family breadwinner
lost time from
LOW BACK PAIN
with
Trancopal®
Brand of chlormezanone
effective oral skeletal
muscle relaxant
and mild tranquilizer

Trancopal enables patients to resume their duties in from one to two days.



In a recent study of Trancopal in industrial medicine,[1] results from treatment with this "tranquil-axant" were good to excellent in 182 of 220 patients with muscle spasm or tension states. From clinical examination of those patients in whom muscle spasm was the main disorder, ". . . it was apparent that the combined effect of tranquilization and muscle relaxation enabled them to resume their normal duties in from twenty-four to forty-eight hours. . . . It is our clinical impression that Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[1] Side effects occurred in only 12 patients, and: "No patient required that the dosage be reduced to less than one Caplet three times daily because of intolerance."[1]

Clinical results with *Trancopal*®[1]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

1506M Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

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SITUATION WANTED: General Surgeon, age 37, Florida license, Part I of surgical Board completed, would like association with another surgeon or group. Write 69-360, P.O. Box 2411, Jacksonville, Fla.

PHYSICIAN WANTED: Rare opportunity in fast growing town of 11,000 needing one or two doctors. Excellent 75 bed, modern hospital. Well equipped office of recently deceased doctor including X-Ray, Laboratory, EKG, etc. County has population of 51,000 with only nine doctors. Adjoining county has no doctor. Financial assistance available. Write 69-385, P. O. Box 2411, Jacksonville, Fla.

FOR SALE OR RENT: Air-conditioned office suite. Suburban Sarasota. Hospital three miles. Part of suite fitted as apartment for doctor until practice established. Reasonable. A. A. Edwards, 2030 Oak Terrace, Sarasota, Florida.

MEDICAL SUITE AVAILABLE. July 1 in St. Nicholas Medical Center, 3127 Atlantic Blvd., Jacksonville. Completely balanced occupancy for medical and dental professions. All utilities furnished including background music· Air-conditioned. Off street parking. Can be leased for $190.00 per mo. Call or write Mr. W. G. Allen Jr., 3102 Atlantic Blvd., Jacksonville. EX 8-5500.

WANTED: General Practitioner and Pediatrician for group practice with present doctors. Unusual opportunity in the fastest growing area of West Coast Florida midway on a main street between St. Petersburg and Clearwater. Inquire: Midway Medical Center, 10700 Seminole Blvd., Largo, Fla., Phone Juniper 4-7215.

SURGEON DESIRES RELOCATION: Age 38. Florida license. Certified by General and Thoracic Surgery Boards. Training included open heart work Prefer private practice in active group but would consider institution if remuneration adequate. Write 69-386, P. O. Box 2411, Jacksonville, Fla.

adult stable diabetics and a significant number of sulfonylurea failures respond to

DBI

trademark, brand of Phenformin HCl

adult stable diabetes

"In our experience the action of DBI on the adult stable type of diabetes is impressive . . . **88% were well controlled by DBI.**"[1]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI], and such control was occasionally superior to that of insulin. This was true regardless of age, duration of diabetes, or response to tolbutamide."[2]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

sulfonylurea failures

Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

"DBI is capable of restoring control in a considerable portion of patients in whom sulfonylurea compounds have failed, either primarily or secondarily."[5]

"All twelve secondary tolbutamide failures have done well on DBI."[6]

"34 out of 59 sulfonylurea primary failures were success-



MODERN OFFICE BUILDING: Florida 2400 sq. ft. one or two man, well equipped and furnished modern office building with lab and X-Ray. Active General Practice going. 12,000 population. Coronary necessitates retirement. Will finance. Write 69-377, P.O. Box 2411, Jacksonville, Fla.

FOR SUBLEASE: Ophthalmologist or RENT specialist. Fixtures and partitions already installed. Will turn patient records and telephone listing over to incoming specialist. Population of 50,000 in west Fort Lauderdale with no eye or EENT in that section. Reason for sublease: wish to leave Broward county. Write or phone LU 1-3770, Suite 110, Romark Bldg., 3521 W. Broward Blvd., Fort Lauderdale.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Adolph B. Cone of Jacksonville announce the birth of a son, Adolph Burl Jr., on March 5, 1960.

Dr. and Mrs. William J. Phelan of Jacksonville announce the birth of a daughter, Kathleen Elizabeth, on April 1, 1960.

Deaths—Members

Aarons, Edwards F., Pensacola	May 30, 1960
Beach, George P., Daytona Beach	June 12, 1960
Berg, George S., Miami	June 13, 1960
Berk, Lester I., Miami Beach	May 20, 1960
Chandler, Isaac W., Daytona Beach	October 5, 1959
Mayhew, Royal H., Palm Beach	June 14, 1960
Moe, Leonard N., Jacksonville	March 28, 1960
Myers, W. Cooper, Tampa	May 16, 1960

Deaths—Other Doctors

Childs, Lansing G., Jacksonville	May 10, 1960
Graves, Alexander W., Titusville	October 6, 1959
Moodie, Bazil M., Tampa	February 23, 1960

BAMADEX®
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets
anorectic-ataractic

A logical combination for appetite suppression

meprobamate **plus** d-amphetamine...suppresses appetite...elevates mood... reduces tension...**without** insomnia, overstimulation or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

Lederle



DBI

lowers blood sugar in mild, moderate and severe diabetes, in children and

not a sulfonylurea...DBI

(N^1-β-phenethylbiguanide) is available as white, scored tablets of 25 mg. each, bottles of 100.

Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corp.



A vine, someone said, is like the human mind–always reaching out for new things to grasp.

PROGRESS...

One way or another people will seek out new ways to cope with old problems. Yet progress must be wisely guided. One doctor says: "The desire of the public to have prepayment medical protection is so urgent that it will buy this protection from whatever plan seems most enticing. Whether you like it or not, prepayment medical care is here to stay. Let us support the system which is voluntary and over which we have adequate control." **BLUE SHIELD**®

The program guided by doctors

‡Service marks reg. by Blue Shield Medical Care Plans

MAIL COUPON

or write to:

Physician Relations Dept.
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532 Riverside Avenue

Please send me samples of available Blue Shield literature which I may distribute to my patients. ☐
Please have a Blue Shield physician relations man visit me in my office ☐ yes; ☐ no.

Name _____, M. D.

Address _____

in rheumatic disorders

whenever aspirin proves inadequate



Sterazolidin®
brand of prednisone-phenylbutazone

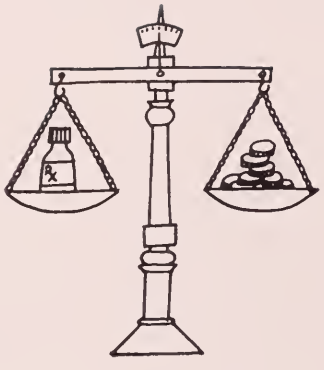
Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60



Unless your practice is limited to bacteriology . . . or your patients are all in the upper income brackets . . . you have doubtless received complaints about the cost of the medication you prescribe.

what your patient

gives...and gets

Some of these complaints can probably be dismissed lightly as coming from cranks, who would complain about your fee for a midnight house call to save the life of a dying child. Others, however, are made seriously by thoughtful patients and deserve an answer in kind. You know what the patient gets from his pharmacist because you have prescribed it. Do you also know that the average cost of a prescription is about $3.00? Only about one in 100 costs $10.00 or more, and 3 out of 5 of the prescriptions are under $3.00. These figures are based on retail prices. They include the manufacturer's research, development, and manufacturing costs and all distribution costs of the wholesale and the retail druggist. Only you and your patients can judge whether today's drugs at these prices represent a fair *quid pro quo*, an equitable balance between what is given and what is received.

This message is brought to you by 138 producers of prescription drugs as a service to the medical profession and in the same spirit, it is carried by this publication. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

Proven

in over five years of clinical use and more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- no cumulative effects, thus no need for difficult dosage readjustments
- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient



Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked*, coated tablets.

* TRADE-MARK

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

CM-2053

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Braman, Robert T., Fort Lauderdale
Breakstone, Irving L., Miami
Churney, Otto L., Miami
Cleveland, Willard H., Cocoa
Cobos, Limbano, Tampa
Duany, Antonio J., Tampa
Dobbrunz, Harry C., Hollywood
Eavey, James L., Cocoa
George, William H., Miami
Hill, William F. Jr., Sebring
Horland, Ephraim, Miami
Hutcheson, James B., Tampa
Kenaston, Thomas C. Jr., Cocoa
Laszlo, Maurice H., North Miami
MacGregor, Howard S., Melbourne
McShane, William J., Coral Gables
Mimnagh, William P. Jr., Pompano Beach
Moore, Dean C., Grassy Key
Mora, Miguel A., North Miami Beach
Perry, Henry D. Jr., West Hollywood
Prevatt, Amos L., Shaw AFB, S. C.
Sacrinty, Nicholas W., Jacksonville
Schmidt, Richard P., Gainesville
Segal, Myron I., Hollywood
Sherman, Marion M. Jr., Cocoa Beach
Smith, Richard T., Gainesville

Associate

Akins, Ernest W. Jr.
Askowitz, Leonard A., Miami
Border, Clinton L. Jr., Miami
Christian, Eugene E. (Col.), Fort Lauderdale
Cohen, Clarence L., Hollywood
Coleman, Julian B., Miami Beach
Egan, John W., Miami
Eller, William C., Pompano Beach
Elliston, Robert L., Fort Lauderdale
Farber, William P., Crystal River
Glass, Frederick W., Lake Worth
Goldstein, Edward S., Miami
Graditor, Milton H., Hollywood
Greenberg, Morris W., Miami Beach
Hahn, Theodore W., Miami
Hatcher, Gordon, Miami
Juliano, Aniello A., Fort Lauderdale

(Continued on page 216)

. . . MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?
OUTMODED AS GODEY'S FASHIONS!

℞ NEW
PRENALIN-O®
PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides

Ferrous Fumarate (Iron)	150 mg.	Vitamin B 12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG
S. J. TUTAG & CO.
DETROIT 34, MICHIGAN





helping the hypertensive to help himself...

THEOMINAL® R.S.

(Theominal with Rauwolfia serpentina)

- **Gradual but sustained reduction of blood pressure**
- **Mild bradycardic action**
- **Alleviation of congestive headache, vertigo, dyspnea**
- **Relief from anxiety, excitability, insomnia**
- **Sense of well-being**

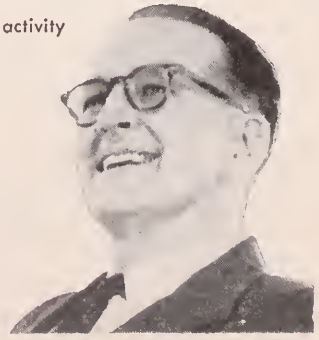
Theobromine	320 mg.
Luminal®	10 mg.
Rauwolfia serpentina alkaloids (alseroxylon)	1.5 mg.*

DOSAGE: The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until resumption is indicated.

SUPPLIED: Bottles of 100 and 500 tablets.

* = 0.3 mg. reserpine in activity

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Theominal and Luminal (brand of phenobarbital), trademarks reg. U.S. Pat. Off.

WHEN
THE PATIENT
WITHOUT
ORGANIC DISEASE
COMPLAINS OF chronic constipation,
flatulence, belching,
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CONSIDER biliary dysfunction and NEOCHOLAN



NEOCHOLAN®

Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

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PITMAN-MOORE COMPANY
DIVISION OF ALLIED LABORATORIES, INC.
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A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Another significant statement concerning the role of fats



FREE: *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.*

Dietary Linoleic Acid and Linoleate—*Effects in Diabetic and Nondiabetic Subjects with and without Vascular Disease*

A paper by Laurance W. Kinsell, M.D., et al., excerpted from Diabetes—The Journal of the American Diabetes Association, May-June 1959

"*Linoleic acid as the major 'hypocholesterolemic agent' in vegetable fats.* The question has been raised as to the mechanism of lowering of the plasma lipids by a variety of vegetable fats. Among the entities present in or absent from vegetable fat which have been considered are: (a) the absence of cholesterol; (b) the presence of certain vegetable sterols; (c) the presence of certain vegetable phospholipids; (d) the nature of one or more of the fatty acids present; (e) the presence of trace materials.

in the diet

The absence of cholesterol has been excluded as a major factor.[5a] Phospholipids, if they contain a sufficient quantity of unsaturated fatty acids may produce a striking reduction. In our experience thus far saturated phospholipids fail to produce such an effect.[7]

Beveridge and his associates believe that vegetable sterols, particularly beta-sitosterol, are responsible to a significant degree for the cholesterol-lowering effect.[8] In our experience the vegetable sterols have a relatively weak and unpredictable effect of this sort.

Since the fatty acids of animal fats are predominantly saturated, and the fatty acids of most vegetable fats are predominantly polyunsaturated, with linoleic acid as the major component of the vegetable fats which lower cholesterol and other lipids, the question arises whether linoleic acid per se is capable of lowering plasma lipids. As reported previously[7] this is indeed the case. In a recent study in a young male with peripheral atherosclerosis in association with elevation of plasma cholesterol and of total lipids, ethyl linoleate produced a greater fall in the plasma lipid levels than had moderate amounts of natural sources of unsaturated fat. Linoleic acid, therefore, appears to be the most important single lipid-lowering component of vegetable fat.

* * *

Significantly higher levels of cholesterol were observed during oleate administration than during administration of equal amounts of linoleate. The relatively low cholesterol values during the second oleate period may have been related to linoleate stored in fat depots. The fatty acid composition of the cholesterol esters reflected the fat which was fed, i.e., the mono-enoic† acid content averaged more than 40 per cent during oleate feeding and less than 20 per cent during linoleate ingestion. Essentially, a mirror image of this resulted during linoleate feeding, at which time di-enoic acid predominated.

* * *

The data presented in this paper appear to establish that linoleic acid administered either as purified ethyl ester or as naturally occurring fat, in sufficient quantity, in properly constructed diets, will reduce plasma lipids to normal levels. The amount of linoleic acid required appears to bear a direct relationship to the amount of saturated fat included in the diet. Linoleic acid requirement may also bear a significant relationship to the amount of atherosclerosis present.

The transition from evaluation of the effect of dietary entities upon plasma lipids, to the evaluation of the effect of such materials upon vascular disease is difficult. However, such evaluation is not impossible. The requisites are adequate measuring sticks and well-controlled studies of sufficient duration. The duration of observation of effects of unsaturated fat in diabetic and nondiabetic patients with vascular disease is in no instance more than five years, and in the majority of instances, less than three. Our present impression is that improvement has occurred in some patients with atherosclerosis and with diabetic retinal and renal disease which was more than we would have anticipated in terms of the natural course of the disease. However, since it is well known that major fluctuations in these diseases can occur in individuals receiving no treatment, we believe it is appropriate at this time to say that no untoward effects appear to result when one prescribes diets containing large amounts of unsaturated fat for patients with such diseases, and it is not impossible that beneficial effects may be associated with such diets."

* * *

5a Kinsell, L.W., Partridge, J. W., Boling, L., Margen, S., and Michaels, G.D.: Dietary modification of serum cholesterol and phospholipid levels. J. Clin. Endocrinol and Met. 12:909, 1952.

7 Kinsell, L. W., Friskey, R., Splitter, S., Michaels, G. D.: Essential fatty acids, lipid metabolism, and atherosclerosis. Lancet 1:334, 1958.

8 Beveridge, J.M., Connell, W.F., Firstbrook, J. B., Mayer, G.A., and Wolfe, M.J.: Effects of certain vegetable and animal fats on plasma lipids of humans. J. Nutrition 56:311, 1955.

† Mono-enoic (mono-unsaturated) acid is presumably synonymous under these conditions with oleic acid and di-enoic (di-unsaturated) acid with linoleic acid

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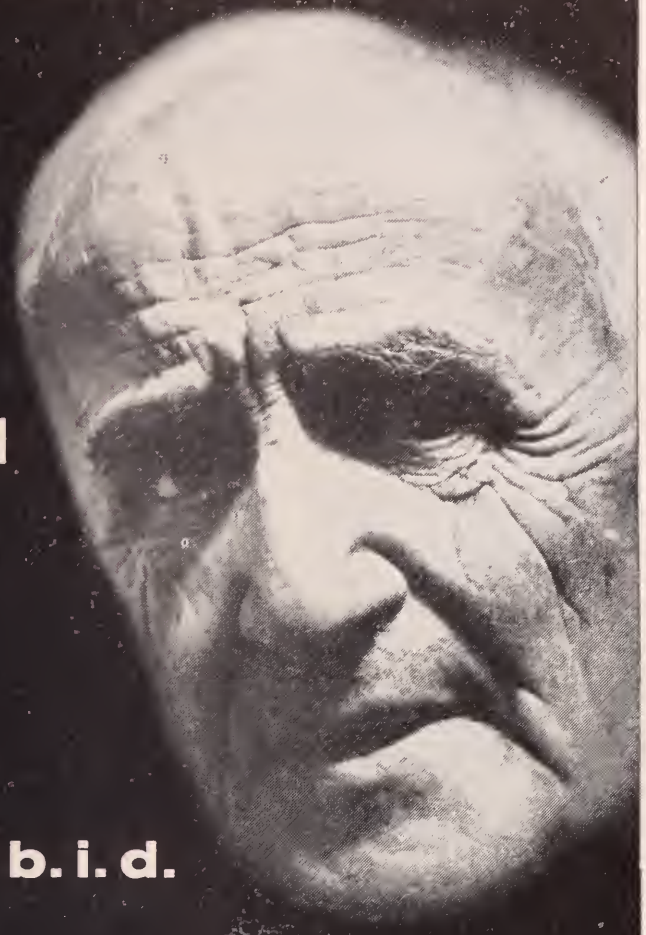
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(Continued from page 208)

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Rein, Harry, Orlando
Rivera-Trujillo, Antonio, W. Palm Beach
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Webster, George D. Jr., Miami
Weiner, Donald M., Miami Beach
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Thank you, Mr. Cunningham, from all of us, and Happy Vacation.

OBITUARIES

Miles A. Collier Sr.

Dr. Miles A. Collier Sr. of Wauchula died of cancer on March 31, 1960. He was 50 years of age.

Born in Colbert, Ga., on Oct. 17, 1909, Dr. Collier received his academic education in his native state. He was awarded the degree of Bachelor of Arts by the University of Georgia at Athens and then attended the Medical College of Georgia at Augusta for three years. He continued his medical training at the Louisiana State University School of Medicine and received the degree of Doctor of Medicine from that institution in 1936. Thereafter, he served an internship at Charity Hospital in New Orleans.

Dr. Collier was Polk County physician for two years before entering the general practice of medicine in Wauchula in 1938. When he first opened an office there, he used the facilities of Bartow General Hospital. In 1947 he assumed ownership of the Wauchula Infirmary, where he continued to practice until a few months before his death. In addition to his medical practice, he

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had extensive grove holdings in the area. Locally, he was a member of the First Baptist Church and the Elks Lodge.

Dr. Collier was a member of the DeSoto-Hardee-Glades County Medical Society and served as secretary of that organization in 1959. Since 1938 he had held membership in the Florida Medical Association and also was a member of the American Medical Association.

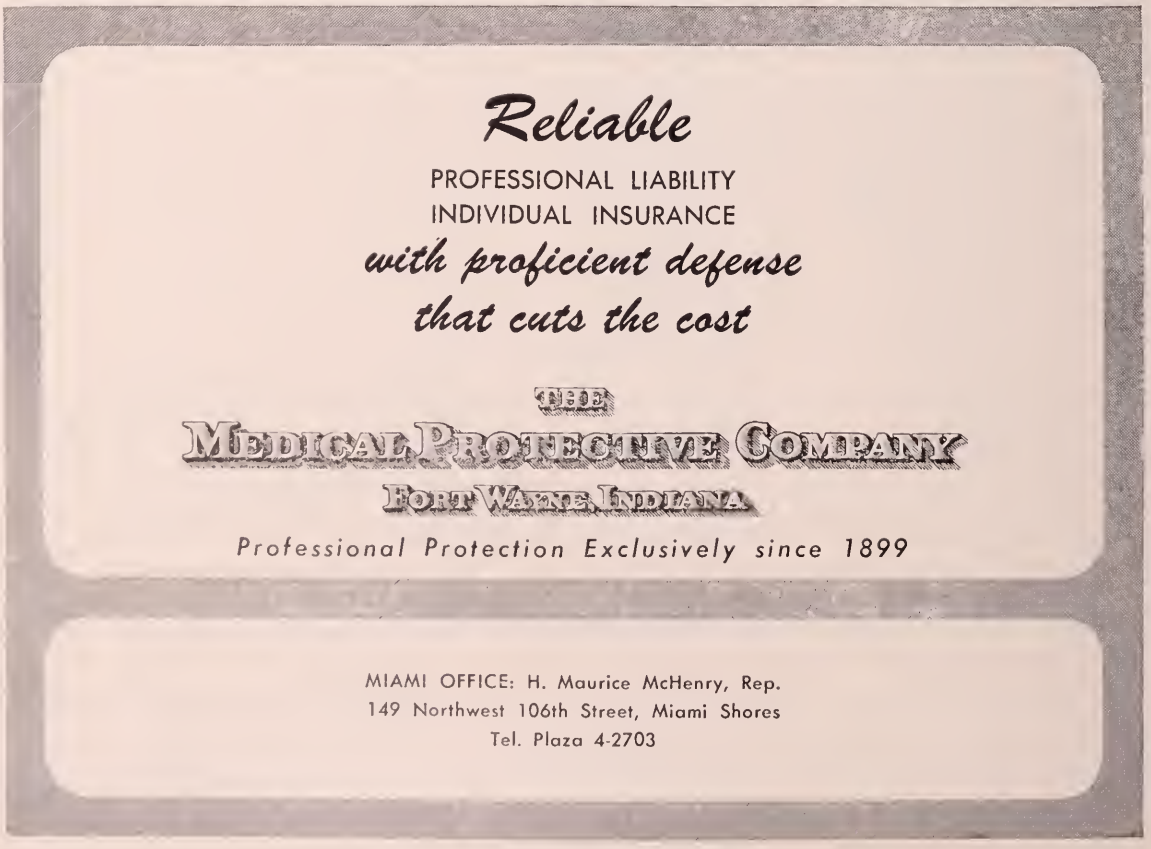
Survivors include the widow, Mrs. Ninfa P. Collier, a son, Miles A. Collier Jr., a daughter, Mrs. Murrell Davis, and one grandchild, all of Wauchula; a brother, Ralph Collier, and a sister, Mrs. Joseph Benton, both of Colbert, Ga.

Stephen Peder Gyland Sr.

Dr. Stephen Peder Gyland Sr. of Tampa died on April 15, 1960 at the Methodist Hospital in Houston, Texas. He was 67 years of age. Burial took place in Tampa on April 19.

The son of Nels and Sesli Gyland, Dr. Gyland was born in Westby, Wis., on Feb. 9. 1893. Upon graduation from Viroqua High School, Viroqua, Wis., he attended St. Olaf College in Northfield, Minn., where he was awarded the degree of Bachelor of Arts. He then served as a sergeant in the Army Medical Corps in World War I. Upon discharge from military service, he attended the University of Wisconsin Medical School for two years and then transferred to the University of Pennsylvania School of Medicine, receiving the degree of Doctor of Medicine from that institution in 1924. Following graduation, he served an internship at Chester Hospital, Chester, Pa.

Dr. Gyland located in Tampa in 1926 and quickly established a large and successful general practice. In 1949 he suffered an illness which totally incapacitated him by 1951 and lasted until 1953. Without a definite diagnosis or encouragement from three leading clinics, he began research on his strange illness. He discovered in Dr. Seale Harris' work on nutrition symptoms which reflected the pattern of his illness and after numerous blood sugar studies and much reading, he became convinced he had a functional hypoglycemia. He worked out a diet and medication for himself and after three months returned to his practice, a well man. Thereafter, he devoted his time to the study and treatment of functional hypoglycemia, presenting a paper on the subject at the 1957 American Medical Association meeting and



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another on hypoglycemia as a cause of neurodermatitis at the 1958 meeting of the Southern Medical Association. In 1960 an annual physical examination revealed an abdominal aortic aneurysm, for which he was subjected to operation in March. Five days postoperatively, he fell from bed and fractured a hip, with death ensuing two weeks later. Locally, Dr. Gyland was a member of the First Presbyterian Church, in which he served as an officer for many years.

A member of the Hillsborough County Medical Association, Dr. Gyland had held membership in the Florida Medical Association for 35 years. He also held membership in the American Medical Association, the Southern Medical Association and the American Academy of General Practice.

Surviving are the widow, Mrs. Ruth Gyland, of Tampa; a daughter, Mrs. Sally Angermeier, of Sherman, Texas; a son, Dr. Stephen P. Gyland Jr., of Jacksonville; three sisters, Miss Martha Gyland, Miss Alma Gyland and Mrs. Webster Clement, all of Tampa; and eight grandchildren.

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Louis S. Goldstein Clinical Medicine 59:455 (1952) / Kass Archives of Internal Medicine Vol. 100, p. 709.

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Stephen A. Dawson

Dr. Stephen A. Dawson of St. Petersburg died in Mound Park Hospital in that city on April 29, 1960. He was 70 years of age.

Dr. Dawson was born in Georgetown, Pa., on Jan. 9, 1890. Educated in his native state, he attended Lindsey College in Pittsburgh, where he was awarded his academic degree. For his professional training he chose the University of Pittsburgh School of Medicine and received the degree of Doctor of Medicine from that institution in 1912. For some years he then practiced otolaryngology in a suburb of Pittsburgh.

In 1924, Dr. Dawson located in St. Petersburg and since that time had continued to engage in the general practice of medicine there. He was still in active practice at the time of his death. Locally, he was a member of the staff of Mound Park Hospital. He was a Mason and a member of the St. Petersburg Yacht Club. His fraternity was Phi Chi.

Dr. Dawson was a member of the Pinellas County Medical Society. He was a life member of the Florida Medical Association, having held membership for 36 years.

Surviving are two sons, Clement V. Dawson and James A. Dawson, and a daughter, Mrs. John H. Williams Jr., of Winston-Salem, N. C.

Royal H. Mayhew

Dr. Royal H. Mayhew died at his home in Palm Beach on June 13, 1960, of coronary thrombosis. He was 72 years of age. Funeral services were held at St. Edward's Roman Catholic Church on June 18 with burial in Antwerp, N. Y.

Dr. Mayhew received his medical training at Albany Medical College in Albany, N. Y., where he was graduated in 1916. He specialized in the field of tuberculosis and chest diseases.

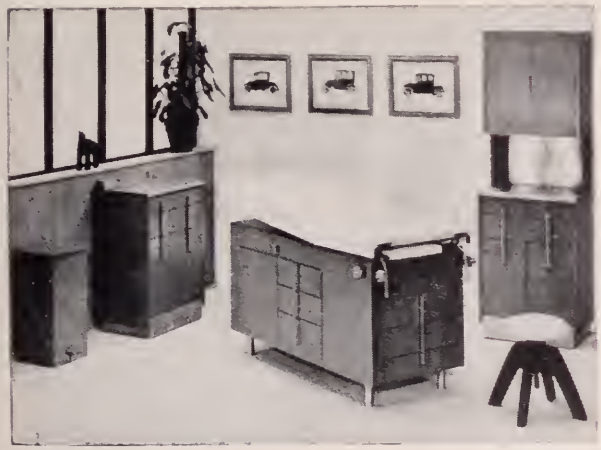
In 1935 Dr. Mayhew located in Fort Lauderdale and engaged in the practice of his specialty. In 1944 he moved his residence to Palm Beach, but continued his practice in Fort Lauderdale. Five years ago, he retired from active practice after sustaining serious injuries in an automobile accident.

Dr. Mayhew was a member of the Broward County Medical Association and for 26 years had

(Continued on page 228)

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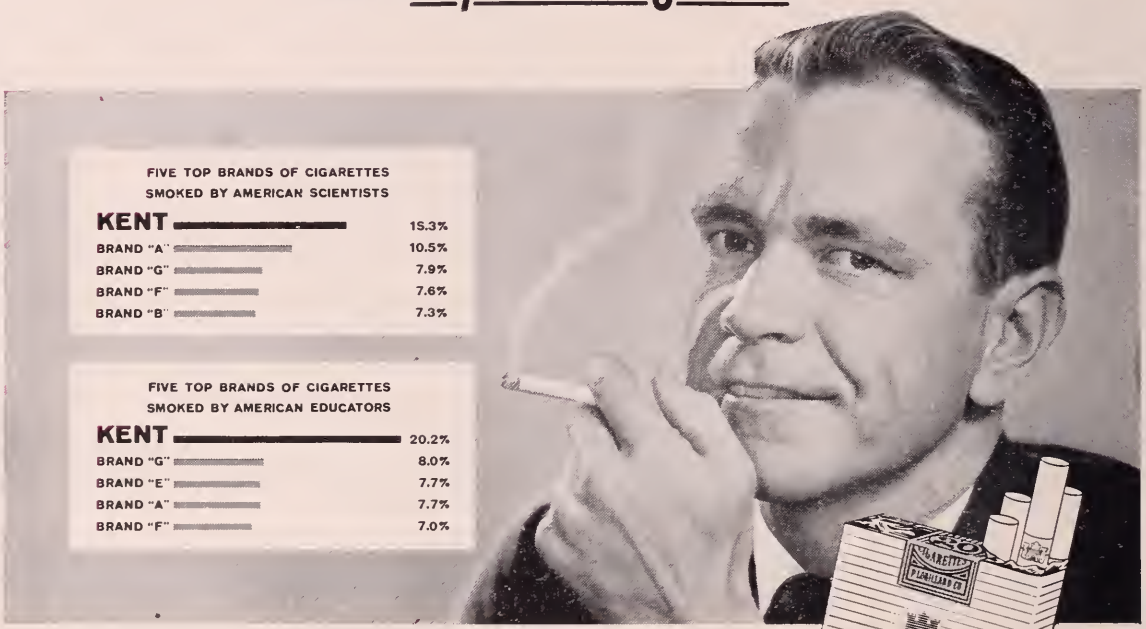
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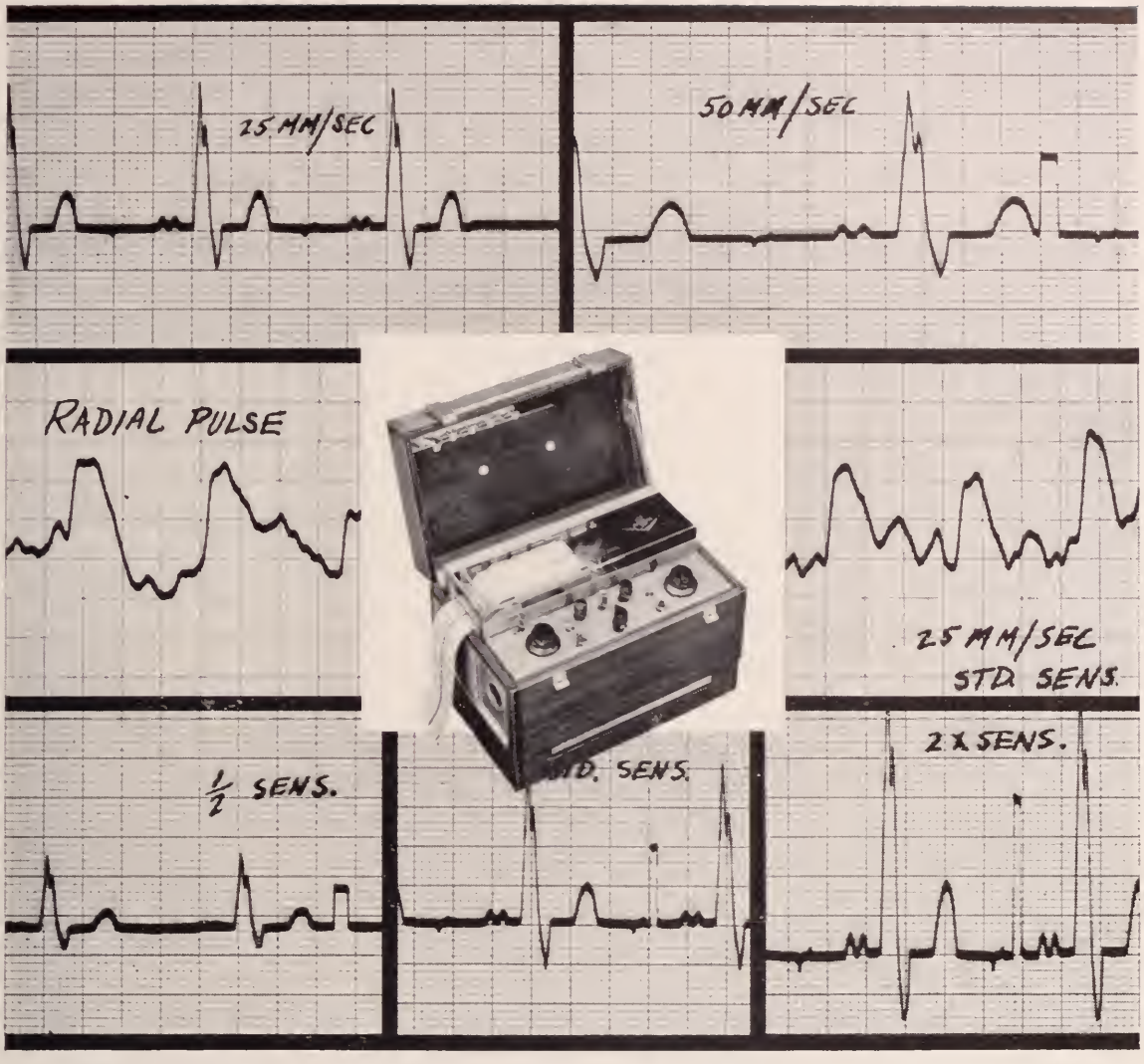
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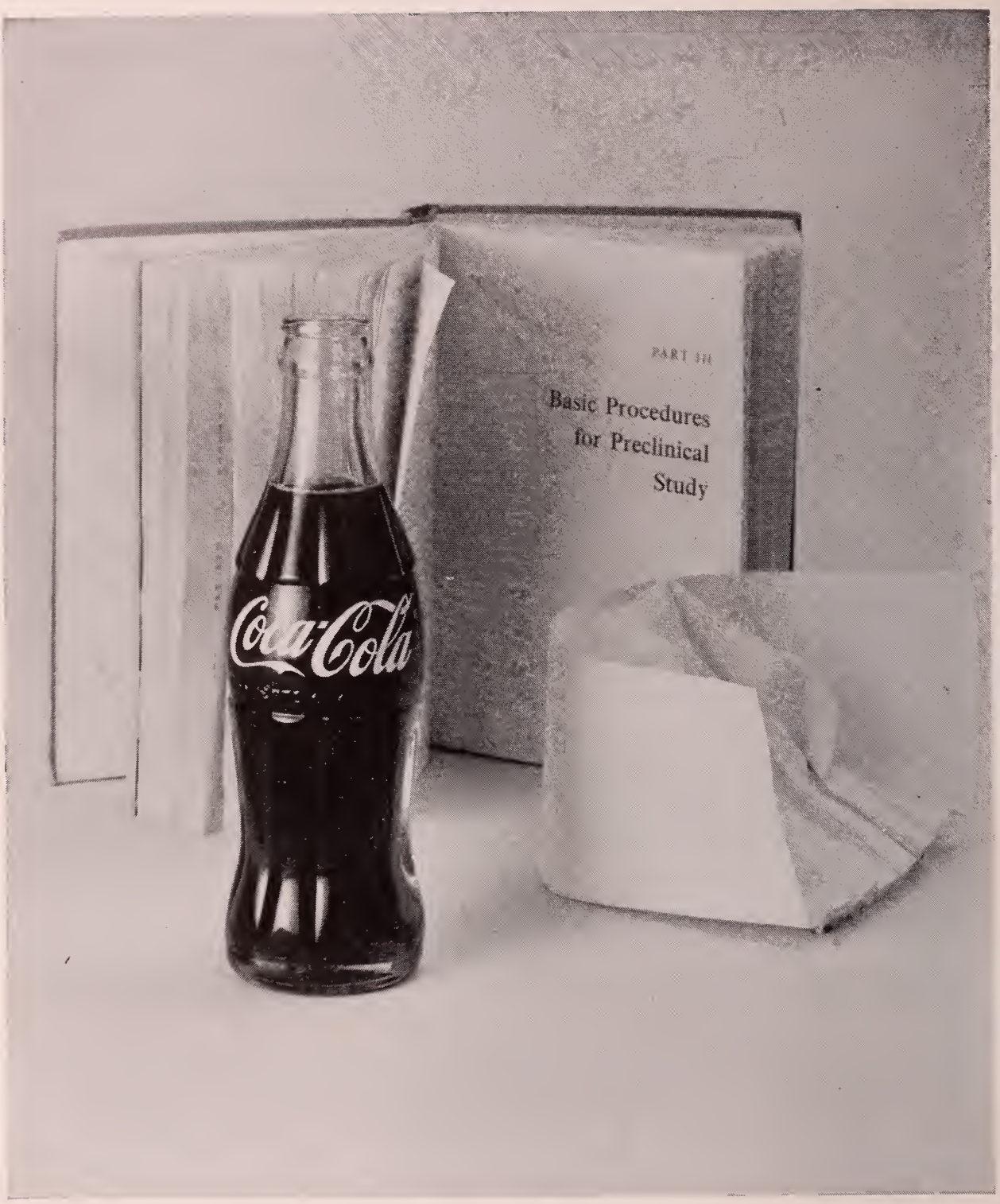
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(Continued from page 221)

held membership in the Florida Medical Association. He was also a member of the American Medical Association, the American College of Chest Physicians and the American Trudeau Society.

Other than a nephew, Dr. Mayhew had no surviving relatives.

BOOKS RECEIVED

Drugs of Choice 1960-1961. Edited by Walter Modell, M.D. Pp. 958. Price $13.50. St. Louis, The C. V. Mosby Company, 1960.

Every physician writing prescriptions is aware of the grave responsibility resting upon him with the tremendous influx of new drugs on the market today—nearly 400 last year alone. The warmly received 1958-1959 edition of Drugs of Choice was offered as a practical guide to the selection of the best drug for a particular therapeutic problem. It proved that members of the medical profession recognize the present urgent need for authoritative and unbiased information on the choice of a particular drug for a particular clinical situation. Accordingly, this 1960-1961 edition appears as a timely revision. It provides the physician with all the essential information he needs on which to make an intelligent therapeutic decision himself, a decision based on the latest clinical evaluation of drugs for the particular condition plus his own knowledge of the patient's history and background. In the present book there are eight new chapters: The Physical and Chemical Considerations in the Choice of Drugs; The Choice of a Local Antiseptic; The Choice of Drugs for Viral, Spirochetal, and Rickettsial Infections; The Choice of Sedatives and Tranquilizers in General Medical Practice; The Choice of an Anorexiant; The Choice of Drugs in Endocrine Dysfunction; The Choice of Drugs for Ophthalmic Use; and The Choice of Drugs for Otolaryngologic Disorders. There are 13 new names in the list of eminent contributors, who number 47 in all. Also, in this edition a single alphabetically arranged all-inclusive Drug Index is used in preference to the separate specialized lists of drugs which followed the individual chapters in the original book. This new edition serves as a truly reassuring consultant to any physician writing a prescription.

Planning Homes for the Aged. Edited by Geneva Mathiasen and Edward H. Noakes. Pp. 128. Price, $12.75. New York, F. W. Dodge Corporation, 1959.

This first comprehensive planning guide ever published on the problems of designing and building homes for the aged and infirm is a pioneering work which is eminently practical. It looks to the future; yet it is contemporary. Each of its 11 chapters of text offering guidance to those actually engaged in planning such homes is written by a contributor of professional distinction and practical experience. They cover such topics as congregate living for older people, community needs and resources, location and building site, common services, residence units and rooms, health needs, administration and staff facilities, materials and costs, design, and the function of the architect. The designs shown are selected from an architectural competition conducted by the National Committee on the Aging in conjunction with Architectural Record and The Modern Hospital magazines. The book is a basic resource of practical value for architects, administrators of homes for the aged and nursing homes, health and welfare bureaus, church groups, and other organizations concerned with the care of the elderly and chronically ill.

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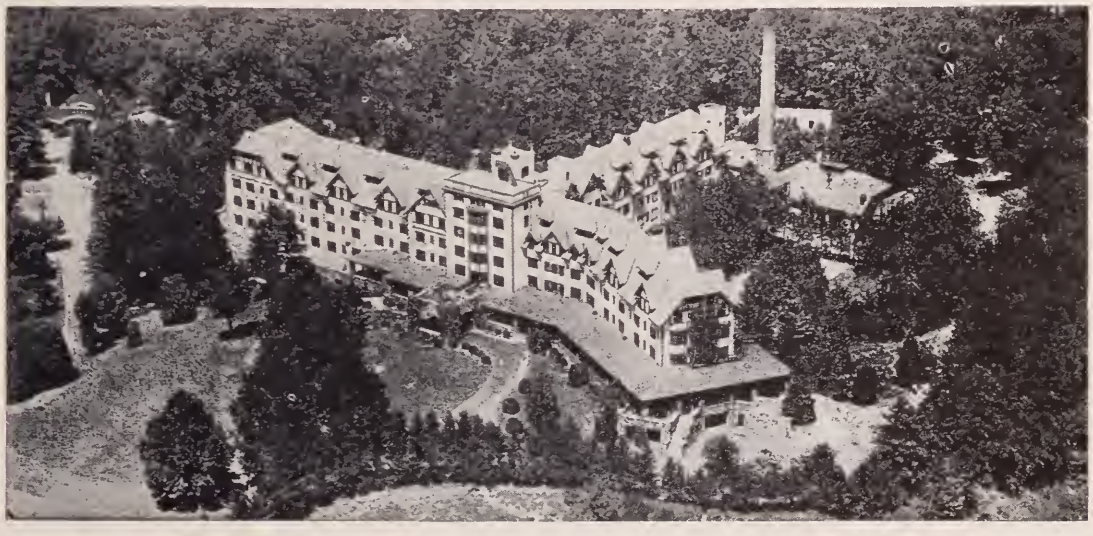
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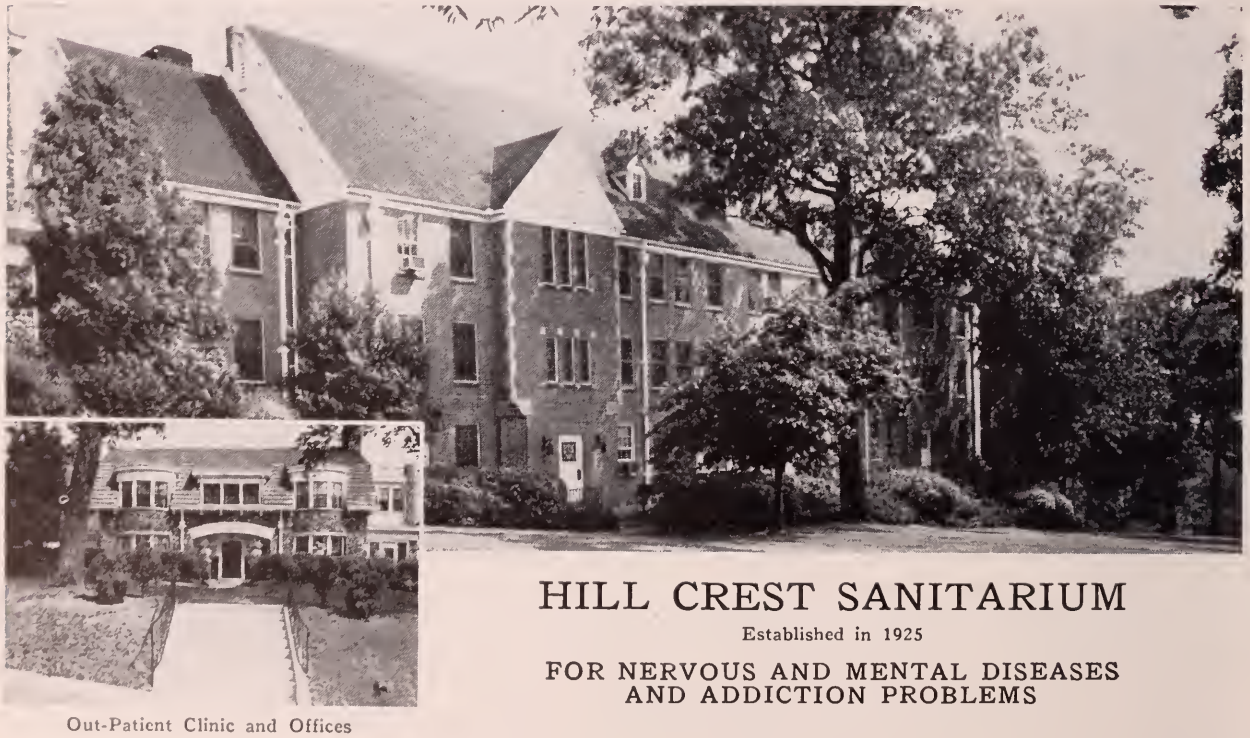
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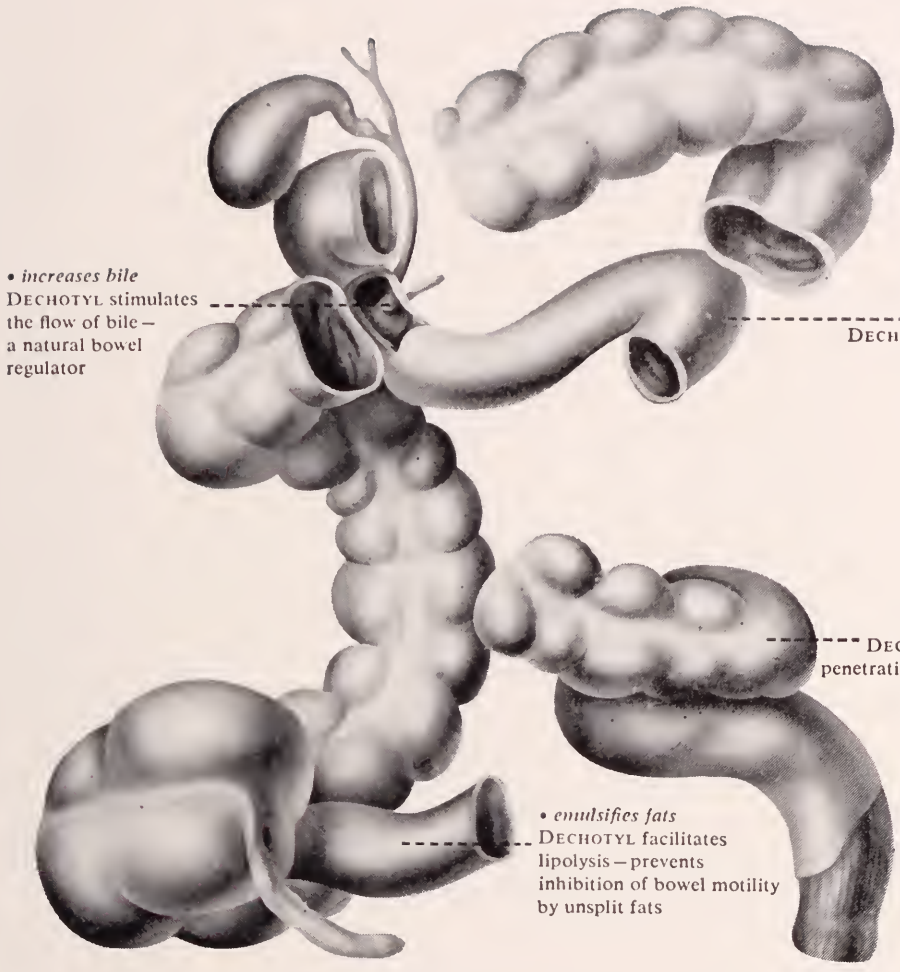
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Brevard	Cyrus E. Warden, Melbourne	Spencer C. Manrodt, Melbourne	1st Tues.	2	73
Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	37	267
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	99	1030
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	6	360
* *Clay*					
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit,, Tampa	Frank A. Massari, Tampa	1st Tues.	2	257
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	4	34
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		39
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	8	76
Madison	Julian M. Durant, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	6
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Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	4	100
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				263	3,776
			Grand Total		4,039

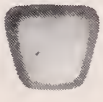


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September, 1960
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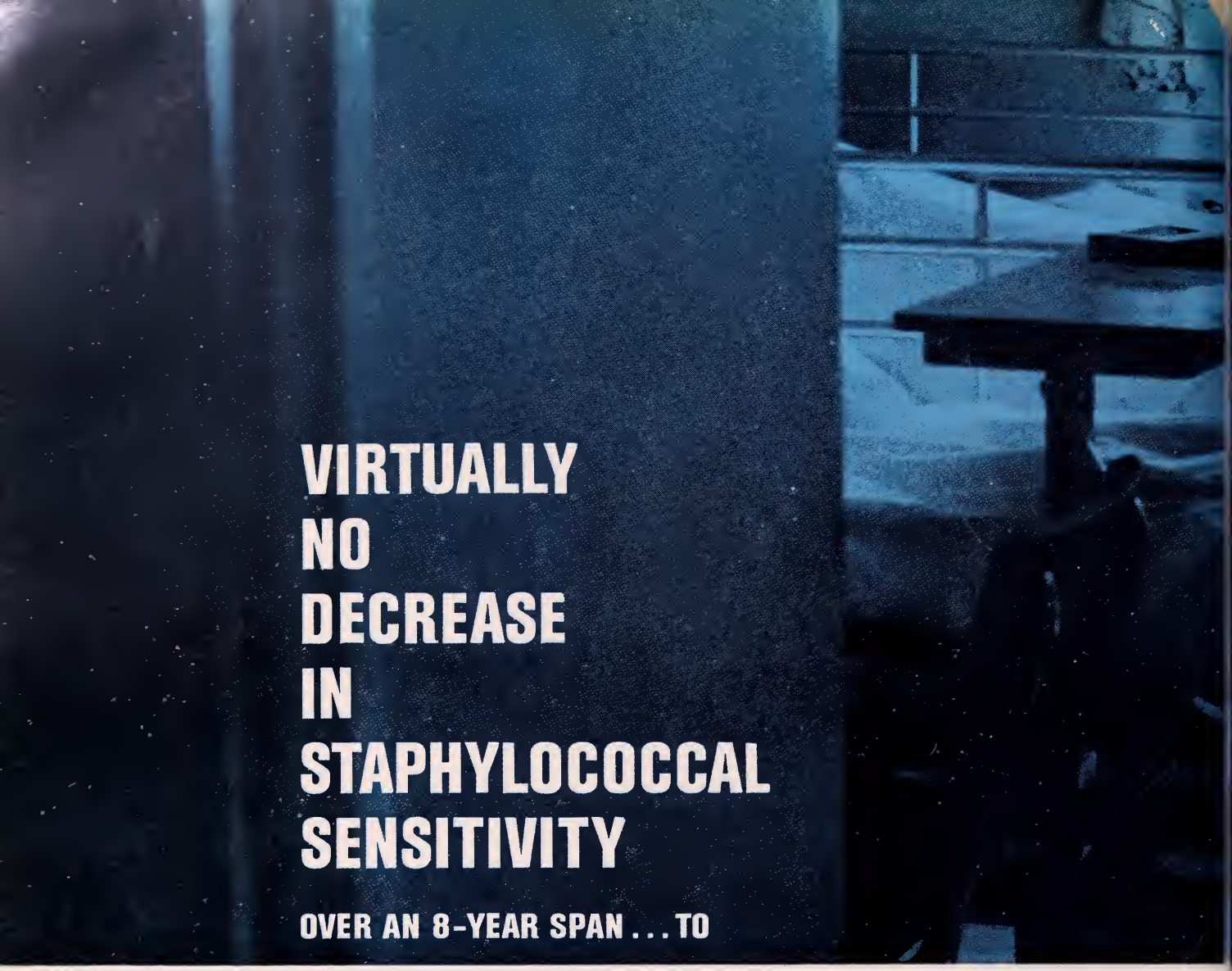
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VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

OVER AN 8-YEAR SPAN . . . TO

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(chloramphenicol, Parke-Davis)

An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (3) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* 15:164, 1960. (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatrics, Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic City, June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* 27:522, 1960.



TRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



stics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

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VOLUME XLVII, No. 3

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• September, 1960

THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

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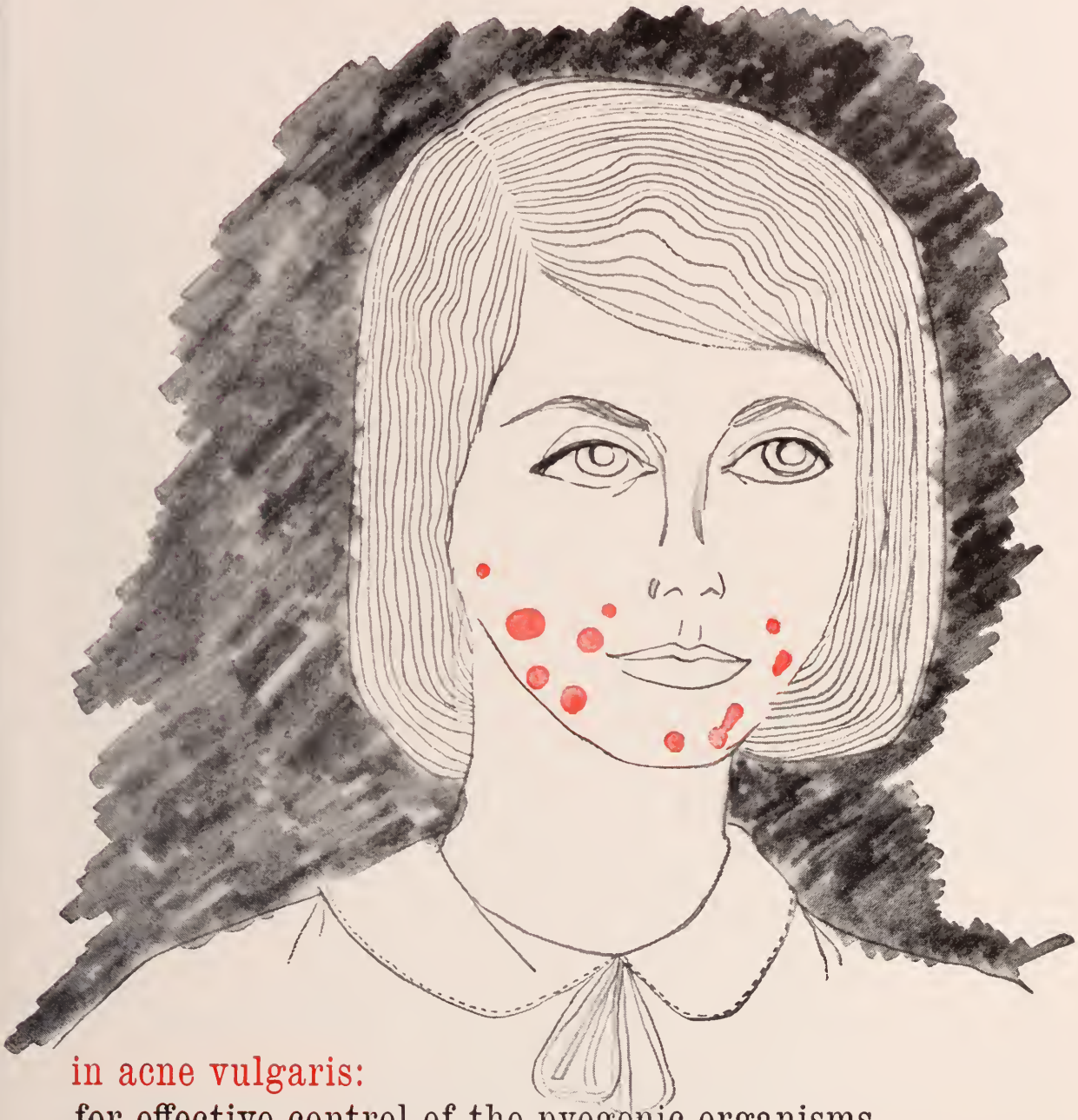
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References: 1. David, N. A.; Parter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Friend, D. H.; Clin. Pharm. & Therap. 1:5 (Mar.-Apr.) 1960. 3. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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References: 1. Steigmann, F., **et al.:** Am. J. Gastroenterol. **33**:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. **6**:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

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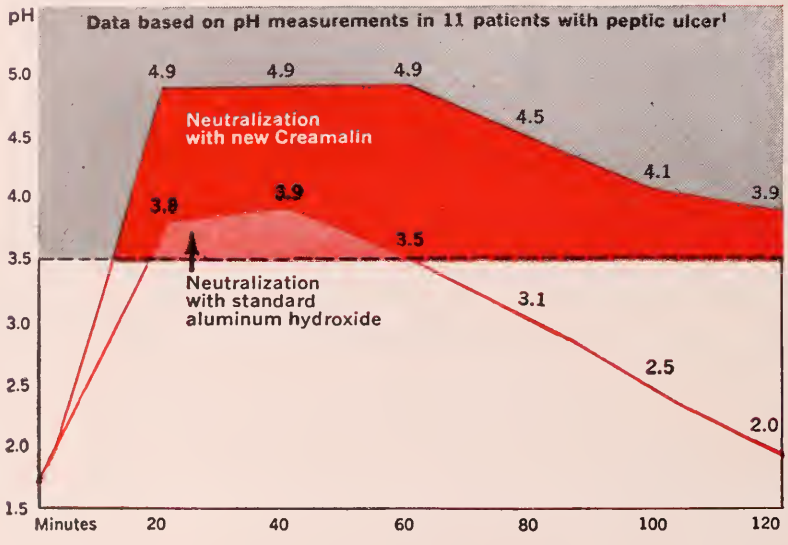
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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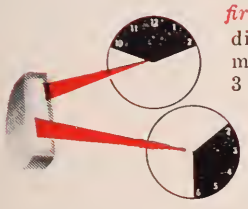
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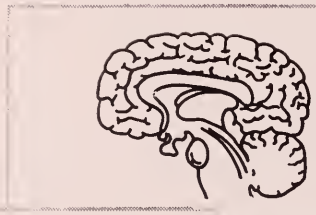
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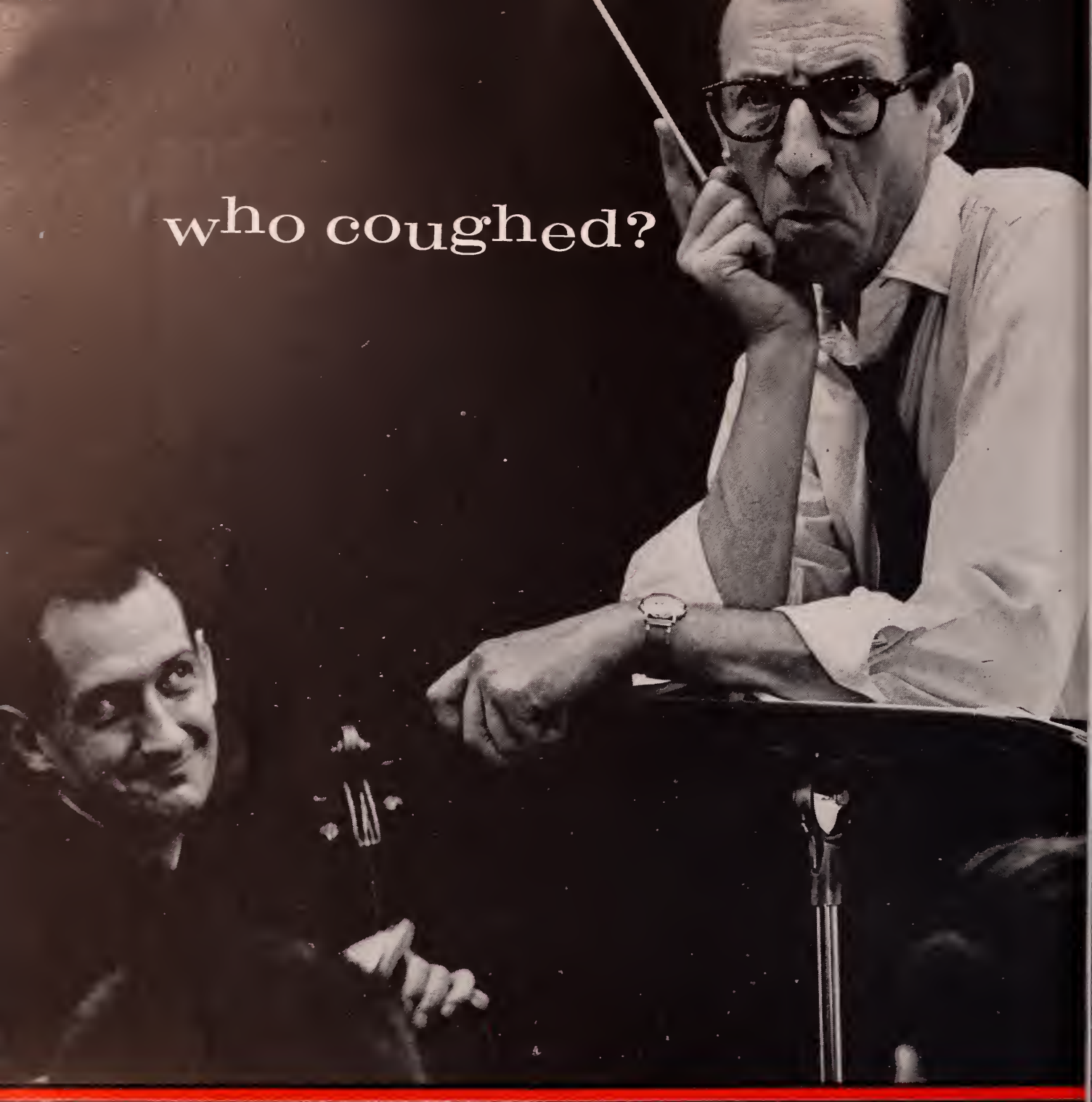
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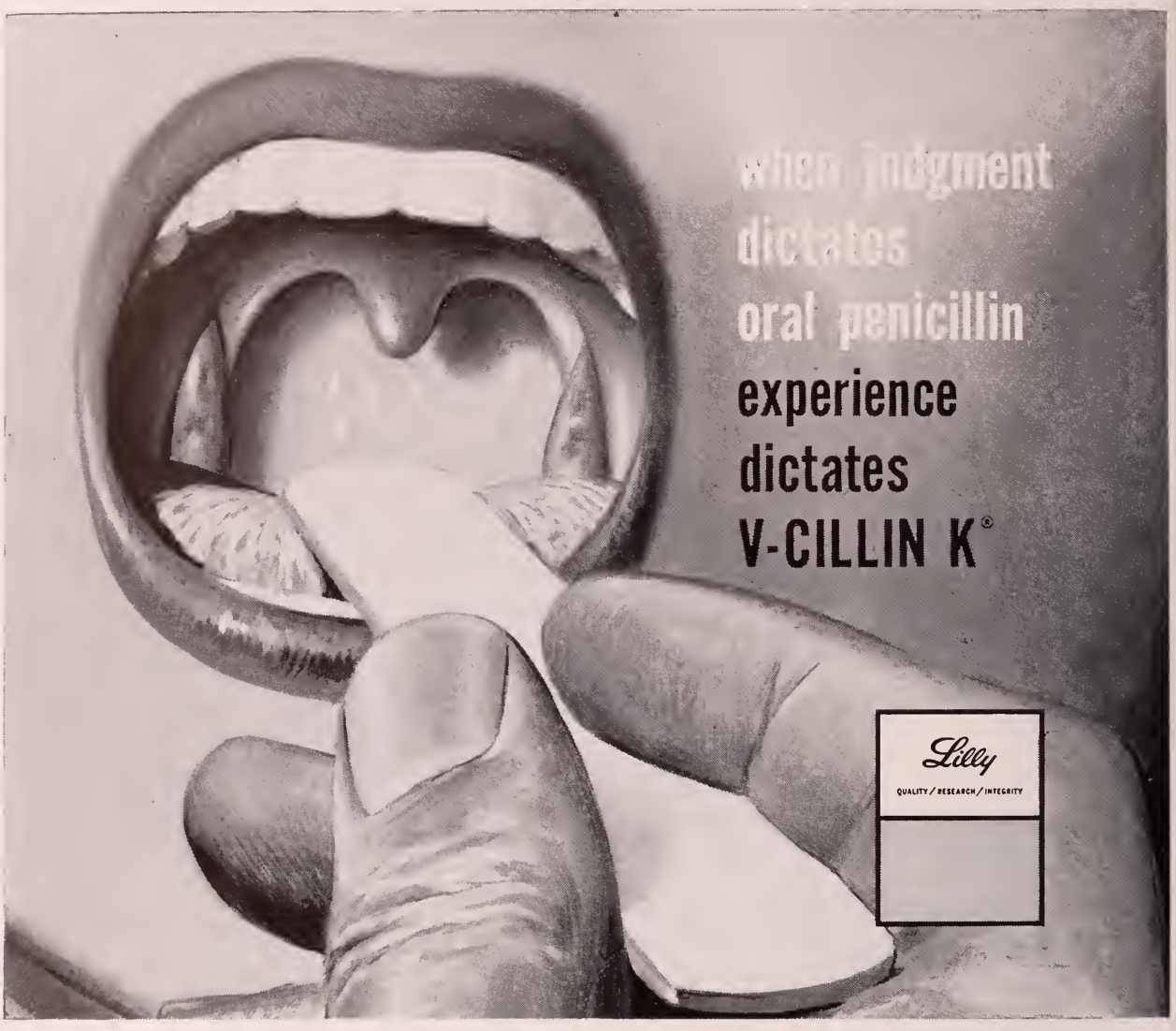
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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVII, No. 3, September, 1960

Some Aspects of the Management of Craniocerebral Injuries

PAUL C. BUCY, M.D.
CHICAGO

Obviously it will be impossible for us to discuss the entire problem of injuries to the brain and skull in the 20 minutes at our disposal. Accordingly, in this limited time I shall try to touch upon a few important points and a few matters which have been receiving special attention recently.

It is hardly necessary to stress the point that every patient who has sustained a cranial injury should be carefully examined. Every patient who has been rendered unconscious as the result of an injury to his head should be admitted to a hospital and kept under close and careful observation for at least 24 hours. Particular attention should be paid to the patient's state of consciousness, the size and reaction of his pupils, and the presence or absence of paralysis or muscular weakness of his extremities.

In years gone by, it was customary to take and record the pulse rate, respiratory rate and blood pressure at frequent intervals. Such data are actually of relatively little value in themselves. Usually alterations in the patient's condition should have been detected before significant changes have occurred in these vital signs. The chief value of having these signs recorded is that we can then be relatively sure that the nurse will see the patient at frequent intervals, and if she has been properly trained, she will note any significant changes in the patient's condition and notify the physician. This latter point is of no little importance. Merely recording the changes in the chart is not sufficient. The nurses must recognize the importance of notifying the physician of such changes, and the physician must be prompt in responding to the nurses' call. I was once called in a case in which important changes in the patient's state of consciousness, in the size and reactions of the pupils and in the respiratory and pulse rates were noted by the nurses, recorded in the chart and the patient's condition allowed to decline until a fatal issue was unavoidable. The physicians in charge of this particular case were not notified until a very slow pulse and Cheyne-Stokes respirations had developed, and by the time they could respond, artificial respiration had become necessary.

X-ray examination of the skull is seldom an emergency requirement. Exceptions to this statement are those cases in which an immediate operation is planned or in which a compound fracture of the skull or extradural hematoma is suspected or is possible. Eventually, however, an x-ray examination of the skull should be made in all cases of craniocerebral trauma. Errors should be made on the side of too many x-ray pictures rather than failing to take any.

Traumatic Extradural Hematoma

Progressive impairment of the state of consciousness and the development of inequality of the pupils in a patient who has been injured recently most commonly indicate the development of an intracranial hemorrhage. Such an occurrence heralds the onset of one of the real acute emergen-

Professor of Surgery, Northwestern University Medical School, Chicago.
From Northwestern University Medical School and Chicago Wesley Memorial Hospital.
Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 11, 1960.

cies in surgery, one which demands immediate action. An incident in our own immediate surgical family at the Chicago Wesley Memorial Hospital illustrates this point, and also demonstrates the fortunate outcome which can result if all those responsible are alert to the situation. In this case a young intern not long out of medical school was the hero. The supervisor of our operating rooms gave a lecture on operating room technics at a hospital in Rockford, Ill. As she was driving back to Chicago following her lecture, she was involved in an automobile accident. She was promptly returned to the hospital where she had just lectured. She did not think she had been seriously injured, but the intern who admitted her noted that she was becoming increasingly drowsy. He suspected that a subdural hematoma was developing. He immediately took steps to prepare the operating room for an emergency craniotomy. He notified the attending neurological surgeon, Dr. John H. Van Landingham, who responded promptly. In the meantime the patient became somewhat confused, and one pupil became dilated and reacted less well to light. At operation, Dr. Van Landingham found an extradural hematoma in the temporal fossa due to a hemorrhage from a torn middle meningeal artery. The hematoma was evacuated and the bleeding controlled. Our supervisor made a rapid recovery and was soon back in charge of our operating rooms. This is an ordinary story. There are many like it, but it illustrates the importance of prompt recognition and prompt action. In cases such as this even a few hours can easily mean the difference between a complete recovery and death.

Not all traumatic extradural hemorrhages are from the middle meningeal artery or in the temporal fossa, although most of them are. We may also see extradural hemorrhages from the intracranial dural sinuses, particularly the sagittal or the lateral. Extradural hemorrhages usually are associated with fractures of the skull—fractures which tear the responsible blood vessel. There are exceptions and they must be borne in mind, but they are uncommon. Whereas, however, most of the fractures which are associated with tears of the middle meningeal artery are merely linear ones in the temporal bone across the artery, the ones associated with extradural hemorrhages from the dural sinuses are usually different. The blood in the middle meningeal artery is under arterial pressure—under sufficient pressure to force its way between the dura mater and the bone and to compress the brain. This is not true of the blood in the dural sinuses. There the pressure is low and not higher than the pressure in the brain and in the cerebrospinal fluid in and about the brain. The pressure in the dural sinuses is not sufficient to strip the dura mater away from the bone. Hematomas can form from tears in the dural sinuses only when the dura mater has been stripped away from the bone by the fracture. This lesion occurs either with depressed fractures or with fractures which were depressed at the time of injury. Because of the low pressure such hematomas develop slowly and often are associated with fluctuating symptoms because of the lower pressures. Such a hematoma should always be suspected in the patient who is not doing well or who is growing progressively worse and who has a fracture across either the sagittal or the lateral sinus.

Traumatic Subdural Hematoma

Other hematomas which develop intracranially as the result of injury to the head are the subdural ones. In fact, subdural hematomas of the various types are much more common than extradural ones. These hemorrhages must be divided into three types as each type is associated with somewhat different symptoms and a different prognosis. The *acute subdural hematoma* is fortunately rare. Hemorrhages of this type develop rapidly following injury to the head. The patient usually never regains consciousness from the initial concussion. He soon sinks deeper and deeper into coma and in spite of all efforts soon dies. Such a patient has sustained a severe injury to some fairly large intradural artery or vein. Because the dura mater and the brain are readily separable, the blood promptly flows into the subdural space and over the surface of the brain. It meets with no restraint. The brain is soon seriously compressed. There are seldom if ever any clinical indications as to which blood vessel has been divided, making it impossible for the surgeon to attack the bleeding point. Furthermore, the compression of the brain occurs so rapidly that the brain has no opportunity to adjust to this space-occupying lesion. Severe cerebral edema develops, the medial surface of the temporal lobe is forced through the opening in the tentorium cerebelli, the midbrain and its venous blood vessels become compressed, and irreversible hemorrhages soon appear in the brain stem which cause the death of the patient.

Subacute subdural hematomas are usually associated with severe contusion and laceration of the temporal or frontal lobes of the brain. The hematomas develop from the bleeding of the torn cortical vessels. The symptoms usually appear within a few days to two weeks after the injury, They are the symptoms of generalized cerebral dysfunction—increasing drowsiness, disorientation and confusion, headaches and vomiting and sometimes convulsions, plus manifestations of localized disturbances of cerebral activity such as unilateral weakness of the extremities with associated disturbances of reflexes, and difficulties with speech, comprehension and reading. Sensory and visual disorders are uncommon. If the condition is not promptly recognized and relieved, stupor, coma, decerebrate rigidity, Cheyne-Stokes respiration and death develop fairly soon.

The following case not only illustrates the development of a subacute subdural hematoma but also the fact that such a hematoma may result from an unusual type of trauma. In this case the patient did not hit his head directly but slipped on the ice and fell on his buttocks. The hemorrhage undoubtedy resulted from the indirect transmission of the jarring force to his head.

Case 1.—A cook, 63 years of age, was admitted to the Chicago Wesley Memorial Hospital on Feb. 2, 1955. On January 27 he slipped on the icy sidewalk and fell, landing on his right hip. So far as is known, he did not strike or injure his head. He was well for three days. He then began to suffer from headaches and became apathetic, confused and somnolent.

On admission, examination revealed a somnolent Japanese man. The cranial nerves seemed intact except for a questionable slight weakness of the left lower portion of the face. There was some retinal arteriosclerosis. No sensory loss could be detected, but a detailed examination was not possible. There was no obvious muscular weakness. The tendon reflexes were more active in the right upper extremity than in the left. Those in the lower extremities were equal; Babinski's sign was not present. There was a slight stiffness of the neck. A lumbar puncture was made. The initial pressure of the spinal fluid was 280 mm. The fluid was clear and colorless. The total protein content was 28 mg. per hundred cubic centimeters. X-ray examination of the skull gave negative results.

Shortly after admission the patient was operated upon, and subdural hematomas were found bilaterally and evacuated through burr holes in the posterior temporal regions. He became more alert in the operating room and stated that his headache was relieved. The next morning he was much better, but that afternoon he again became somnolent, his right pupil dilated and a left hemiparesis developed. He was again operated upon that afternoon, February 4. A right subtemporal decompression was made, and a rather large amount of old blood, some of it clotted, was removed from the subdural space. Again his condition improved promptly, but the improvement did not persist. Once more he became lethargic. A lumbar puncture revealed a pressure of only 150 mm. of fluid. Nevertheless, because of his deteriorating condition, he was taken back to the operating room on February 7, and bilateral burr holes were made in the frontal regions. Subdural hemorrhagic cysts were found bilaterally. These were separate from and did not communicate with those previously exposed and evacuated. Following this operation he improved steadily. The next morning he was able to converse freely in Japanese as well as in English. On February 12 he sat on the edge of his bed. On February 14 he walked with assistance and on February 21 he was discharged from the hospital. He recovered completely and soon returned to work. He continued to work until the summer of 1959 when he retired at the age of 67 years. He is still in good health.

Discussion.—This case illustrates the appearance of serious neurological complications from the development of multiple subdural hematomas a few days following an unusual indirect cranial injury resulting from the patient's having fallen on his buttocks. It also illustrates several other important points. First, a subdural hematoma, especially a subacute one, may be incompletely evacuated through burr holes. As a result, reoperation with a wider exposure and possibly a subtemporal decompression may be required. Second, it is not uncommon for the patient to have bilateral subdural hematomas, and such should always be looked for whether or not the patient's symptoms indicate their presence. Third, it is by no means rare for a patient to have two separate subdural hematomas on the same side of the skull which do not communicate with each other. Whenever the patient's condition is not progressing satisfactorily, such a possibility must be considered. Lastly, it should again be pointed out that the level of the pressure of the cerebrospinal fluid and the findings on examination of that fluid are not reliable criteria in recognizing the presence of a subdural hematoma. In many cases the best way to establish the diagnosis is to make bilateral burr holes in the skull.

Chronic subdural hematoma is actually quite a different condition. The patients usually belong in the older age groups, and the incidence of chronic alcoholism in those in whom chronic subdural hematomas develop is high. Here the relationship to craniocerebral trauma is often remote or not apparent. The following case is typical of this group in several ways. Notably, the patient was a chronic alcoholic, and we elicited no history of trauma. The case also illustrates another important point. The localizing neurological signs which are reliable in the case of most lesions of the nervous system may be misleading in cases of subdural hematoma. In this case the hematoma gave rise to changes in the arm and leg on the same side as the hematoma rather than on the opposite side. The findings on examination of the spinal fluid—moderate eleva-

tion of pressure, a faintly yellow fluid and a slight increase of protein—were typical of this condition.

Case 2. — A 49 year old man was referred by Dr. W. Sittler and Dr. D. Raines of Chicago. He was admitted to Chicago Wesley Memorial Hospital on Aug. 31, 1958. He was said to have consumed large amounts of alcoholic beverages for several years.

There was no history of injury, and the patient was apparently well until August 22 when without apparent cause he lost consciousness at work and remained semistuporous. He was taken to another hospital, where his condition improved. He was discharged on August 29. Later that same day he again became unresponsive. His condition continued to deteriorate, and he was admitted to Chicago Wesley Memorial Hospital on August 31 in a semistuporous condition. His pupils were round and equal and contracted to light. He moved all four extremities in response to painful stimuli. There was no inequality in his reflexes, and Babinski's sign was not elicited. On spinal puncture the pressure was 330 mm. of fluid. The fluid was slightly xanthochromic. The total protein content was 54 mg. per hundred cubic centimeters. X-ray examination of the skull gave negative results except for a slight shift of the calcified pineal gland toward the right side.

The following day he was more stuporous. There appeared to be a weakness of the right side of the face, the right extremities were moved less than the left, the tendon reflexes were more active on the right, and Babinski's sign was present on the right. He was operated upon that morning. The left side was explored first, and no abnormality apart from an increased intracranial pressure was found. Accordingly, a subtemporal decompression was then made on the right side, and a very large subdural hematoma was found and evacuated. Improvement began immediately and progressed rapidly. He was discharged from the hospital 12 days later. He soon returned to work and has remained well since.

Fractures

Although the presence or absence of a fracture of the skull is commonly of great concern to the family, the patient and the lawyer, it is much less important from a strictly medical viewpoint. Most fractures of the skull are of the linear variety and such fractures of and by themselves are seldom of any importance, except that they do indicate that the patient has sustained a craniocerebral injury. Depressed fractures are always associated with more or less injury to the underlying brain. The damage which is done to the brain usually occurs at the time of injury. Nevertheless, we would subscribe to the commonly held view that it is usually best to elevate such fractures. In most cases this procedure should be done for the patient's peace of mind if for no other reason. If, however, it is not compound, the elevation of a depressed fracture is seldom an urgent matter.

Compound fractures always present added problems as they provide potential pathways by which infection may enter the meningeal spaces or the brain. This observation is true regardless of whether the fracture communicates to the outside or with the paranasal sinuses or the ear. Antibiotics have greatly decreased the seriousness of injuries of this type, but have not altered the need for prompt cleansing, and debridement of such wounds and elevation of the depressed bony fragments. Whether the individual fragments will be retained or discarded will depend in large measure on how soon the wound is operated upon, how great the contamination is, and how large the fragments are. Whenever it appears feasible, large fragments should be replaced in the defect in the skull. Of course, antibiotic therapy should be continued for some time after the wound has healed, and in those instances in which there is evidence that a fracture has extended into the roof of the nose, the paranasal cavities or the ear, such therapy should be continued for a minimum of two weeks regardless of how complete the patient's recovery appears to be.

Fractures which extend into the nose and paranasal sinuses may be associated with the development of air in the ventricular system or air in a cavity in the brain substance, and with an intracerebral abscess. Air within the skull secondary to a craniocerebral injury is almost always indicative of a communication with the nose. Closing of such communications may take place spontaneously and the air be absorbed. If this does not occur fairly promptly, the patient should be operated upon, the communication with the nose closed and the air within the brain released. If an abscess has developed, the pus should be evacuated and the cavity treated properly.

General Measures

Thus far we have dealt with specific situations which may occur in patients with craniocerebral injuries. Now I should like to discuss with you certain general measures in the treatment of these patients.

Adequate Airway

Certainly the most important single factor in the care of the comatose patient is the maintenance of an adequate airway, and one might also say, the most commonly neglected. *No unconscious patient should be allowed to lie flat on his back.* In this position fluids will accumulate in the pharynx and even run down the trachea. The respiratory exchange will soon become inadequate, and pneumonia will probably develop. Such a patient should be turned onto the abdomen and maintained in a three-quarter position with a pillow or other support under one shoulder. It may also be desirable to elevate the foot of the

bed. In this position secretions will run from the mouth, no fluid can accumulate in the pharynx, and drainage of the tracheobronchial tree will be encouraged. Even this measure will not prevent the accumulation of thick mucus in the trachea. When this happens, or when it is obvious that the patient's respiratory effort is unduly labored or that his respiratory exchange is inadequate, a tracheotomy should be performed without delay. I know of no other single procedure which will produce as dramatic improvement in the patient's condition, in properly selected cases; infrequently, it will convert what appears to be a completely hopeless situation into one of prompt and continuing improvement which will lead on to ultimate recovery. The following case illustrates this point and the importance of continuing effort even in the face of what may appear to be hopeless odds.

Case 3.—A 48 year old pullman car attendant at about 1:30 p.m. on Oct. 2, 1956, was struck over the head and robbed. He was taken by the police to another hospital. His wife said that he was conscious at that time, but complained that his left arm was paralyzed. He was transferred to the Chicago Wesley Memorial Hospital where he was admitted at 3:10 p.m. in a semistuporous, restless condition. His respirations were labored, and the left cheek blew out more than the right on expiration. The right pupil was larger than the left, but both reacted to light. There was a soft swelling over the right parieto-occipital region. The right leg was spastic, the left flaccid. He threw the right arm and leg about violently, but not the left ones. Babinski's sign was present on the right. He vomited twice shortly after admission. X-ray examination of the skull revealed a depressed fracture in the right parietal area. The stupor was deepening, and it was recognized that he probably had a right extradural hematoma. He was taken directly to the operating room, and under local anesthesia the depressed fragments were removed, exposing a massive extradural hematoma. This extended from the mid portion of the temporal fossa inferiorly to the superior longitudinal sinus above, anteriorly to the coronal suture and backward to the lateral sinus. The hematoma was evacuated. The middle meningeal artery had been lacerated and was bleeding briskly. The bleeding was readily controlled. The dura mater was sutured to the margins of the bony defect, and the defect was repaired with a stainless steel plate.

The patient's condition improved slightly in the operating room, and by the close of the procedure he was moaning, restless and moving his left extremities a little. Thereafter, his improvement did not continue. He developed a right hemiparesis and severe pulmonary involvement. The temperature was elevated and on October 8 reached 106 F. On one occasion on October 9 the fasting blood sugar rose to 338 mg. per hundred cubic centimeters (it had been normal earlier), and glucose appeared in the urine.

On October 10, bifrontal and parietal burr holes were made, but no extradural or subdural effusion was found. On October 13, a tracheotomy was performed because of the abundance of tracheobronchial secretions. Within a very short time there was a striking improvement in the patient's condition. For the first time since the removal of the extradural hematoma he would open his eyes and follow simple commands. From that point onward he improved. Movement returned first to the right and then to the left extremities. Insulin was no longer needed after October 21. Nasal tube feeding was required. On October 27 he began taking liquids by mouth, but at times he would choke on these and the fluids would appear from the tracheotomy tube. It was thought that in view of the bilateral hemiparesis this condition probably was due to a difficulty in swallowing from a supranuclear palsy. Accordingly, the stomach tube was reinserted, and he again progressed more rapidly. On October 31 he was able to be up in a chair for 45 minutes and was able to stand by the bedside. The tracheotomy tube was removed on November 15, but because of persistent difficulty in swallowing, the nasal tube could not be removed until November 18. On the same day he was able for the first time to take a few steps. Gradually his walking improved. Intensive physiotherapy had been continued by the nursing staff throughout his long illness. The pain in various joints and the diffuse spasticity on both sides had gradually improved. By December 1 he was able to dispense with the walker and on December 6 he was discharged from the hospital.

Since then his condition has gradually improved although he still has trouble with his vision, and with the left upper and right lower extremities. When he was last examined three years after the injury, we found a pleasant appreciative man who spoke slowly but well. The visual acuity was 20/50 bilaterally, and there was an incomplete left homonymous hemianopia. There was a mild right lower facial weakness. Protrusion of the tongue was limited and slow. There was a subjective diminution of pain sensibility on the entire right side of the body, including the face. Perception of vibration was decreased in both lower extremities, and position sense was not quite perfect in the left toes. There was no weakness on the right side, but muscular resistance to passive movement was somewhat increased on the right. The fingers of the left hand, especially the fourth and fifth, were moved slowly and awkwardly. All tendon reflexes in the upper extremities were hyperactive. Those in the lower extremities were not. Babinski's sign was not elicited. He favored his right leg slightly as he walked.

Discussion.—This case is a dramatic example of the value of tracheotomy in some cases of severe craniocerebral injury.

In this case it appears that a massive extradural hematoma produced a shift of the brain with serious involvement of the brain stem. This caused difficulty in swallowing, involvement of the right extremities, in addition to the left ones which had previously been involved, and a disturbance in sensory perception. In many cases involvement of the midbrain following the development of a massive intracranial hematoma produces an irreversible situation. That such is not always the case is well illustrated here. The intense effort exerted in this case by the nursing and resident medical staff headed by Dr. Donald Ullrich, now of Milwaukee, has been well repaid.

Restlessness

Many a patient is extremely restless following a craniocerebral injury. The proper means of combating this situation are often problematic. In many instances the patient is restless because he is in pain or distress. If the pain is due to moderately increased intracranial pressure or to blood in the cerebrospinal fluid, it can often be

relieved by a lumbar puncture. In other cases reasonable amounts of codeine may be required. Many a patient is restless because of a distended bladder. When such is the case, catheterization will often allay his restlessness. If he is unconscious, an indwelling catheter should be left in place, not only to avoid distention of the bladder but also to keep him and his bed dry. In some patients these simple methods will not suffice, and one must decide whether sedatives are to be used. During the early hours after an injury sedatives may be undesirable because the calm which they induce may conceal the development of an impairment of consciousness which is indicative of an intracranial hemorrhage.

Equally serious is the question of how long sedatives, once begun, are to be continued. In many instances, once the patient has been quieted with barbiturates or paraldehyde, the attending nurse finds that whenever the patient begins to awaken, he becomes confused and obstreperous. Thus she and the attending physician are often tempted to administer another dose of sedative. This treatment can go on indefinitely while the patient's condition deteriorates, he becomes malnourished and rigid, and decubitus ulcers develop. In many such cases it is necessary to discontinue all sedatives and allow the patient to pass through a noisy period of confusion, for many hours if need be, while he arouses from his drugged stupor. It is important in many cases of stupor with apparent decerebrate rigidity to distinguish between traumatic injury to the brain and overmedication.

Spinal Puncture

Spinal puncture has been mentioned in passing. In years gone by, the question of whether a spinal puncture was or was not to be made divided those who treated craniocerebral injuries into two camps. In large measure the controversy over this point has ended. There is certainly no justification for making a spinal puncture on every patient who has sustained an injury to his head; neither is there any justification for saying that one should never perform a spinal puncture on a patient who has sustained a craniocerebral injury. Such tests should be carried out whenever they are indicated and not otherwise. What are the indications? Such punctures should be made whenever the attending physician thinks that there may be blood in the spinal fluid and that a removal of part of it will help to improve the patient's condition; whenever a temporary relief of increased intracranial pressure appears indicated; whenever it appears likely that examination of the fluid, as for pus or blood, will contribute to a better understanding of the case.

There are also contraindications. A spinal puncture should not be performed in cases in which cerebrospinal fluid is being discharged through a fracture, be that through the scalp, through the ear or from the nose. To do so may encourage the entrance of infectious organisms into the intracranial cavity through the compound fracture. Neither should a spinal puncture be made when there is reason to believe that there may be herniation of the medial surface of the temporal lobe through the tentorium cerebelli with its attendant compression of the midbrain and its venous drainage.

Dehydration

Twenty-five or 30 years ago dehydration played a prominent role in the treatment of patients with craniocerebral injuries, and then was largely discarded. In the past few years this form of treatment in slightly different garb has again gained considerable attention. It matters little whether one dehydrates the brain by administering hypertonic glucose or sucrose or lyophilized serum intravenously, or administers magnesium sulfate by mouth; whether one denies the patient fluids, or provokes a massive renal excretion by administering urea. He is reducing the size of the brain by the simple process of depriving the body of much of its fluid. It is not possible to extract water from the traumatized brain without simultaneously dehydrating the rest of the body. This deprivation the body will not tolerate for long. If one persists with this form of treatment, the patient's temperature will rise, the renal function will become impaired, nitrogenous products will accumulate in the body, and the patient will become ill from the treatment as well as from his injuries. Dehydration has no place in the prolonged treatment of patients with craniocerebral injuries. Does this mean that dehydration should never be used as a form of treatment in such cases? Certainly not, but it does indicate that such treatment should not be used as frequently as it was years ago, or as it is being used in some quarters today.

What are the indications for the use of urea or for dehydrating the traumatized brain? So far as I can see, there are only two situations in which such treatment is beneficial. If one is planning some form of permanent decompression of

the brain, such as the surgical removal of a hematoma, but is prevented for one reason or another from performing the operation immediately, it may be worth while to dehydrate the brain temporarily until the operation can be carried out. The other situation is quite different. On occasion, a vicious circle becomes established. As the brain becomes swollen, the capillary bed and the veins draining the brain become compressed and obstructed, thus interfering with the free flow of blood from the brain, increasing the cerebral edema and further heightening the intracranial pressure. In such cases dehydration of the brain may reverse this process, re-establish adequate venous drainage and set the patient on his way to recovery. For this purpose urea is a satisfactory dehydrating agent. Unfortunately, such situations are uncommon, making the use of urea in cases of craniocerebral trauma disappointing all too frequently. In many instances, however, the only way to determine the value of dehydration is to try it. If improvement does not occur fairly promptly, the use of urea should be discontinued as prolonged dehydration itself can cause serious complications. In addition, urea should not be used in patients in whom intracranial bleeding is probable unless prompt surgical intervention is contemplated.

Decompression

In years gone by, surgical decompression was commonly resorted to in cases of craniocerebral injury. In fact, it is said that in some clinics as many as 33 per cent of all patients were thus operated upon. Occasionally, a surgical decompression will prove of value, but in general unless there is a depressed fracture to be elevated or an expanding mass of blood, fluid, air or pus to be removed, there is little to be gained by a simple decompression. In recent years some surgeons have been considering a very radical decompressive attack in some cases when a very severe cerebral contusion with marked swelling of the brain exists. Not infrequently a badly contused brain, usually in the temporal or frontal areas, often bilaterally, will become very edematous, and multiple petechial hemorrhages will develop within its substance. If this condition persists, the medial surface of the temporal lobe will be forced downward through the opening in the tentorium cerebelli alongside the midbrain (an uncal herniation). This will compress the veins draining the brain stem. As a result, edema and hemorrhage will develop in this important structure, and unless the condition is promptly relieved, the patient will die.

In such cases some surgeons have carried out amputations of the tips of the temporal lobes or of the frontal lobes as the case may be; others have removed, temporarily, large blocks of bone from the frontal regions bilaterally and left the underlying dura mater open. Still other surgeons have made subtemporal decompressions and slit the tentorium. The difficulty with all of these procedures is that by the time it is apparent that such drastic surgery is warranted, the damage to the midbrain is commonly so severe that the process has become irreversible. In such cases the worst result that can be obtained may be for the patient to live. The life of the patient may be preserved only to have him survive as an unintelligent vegetable of no value to himself and a great burden and source of grief and despair to his family and the world in general. It is not that such decompressive procedures are without value. The difficulty is to recognize sufficiently early those cases in which they are needed without, in one's mistaken enthusiasm, performing such drastic operations unnecessarily. There are no absolute criteria upon which to rest the decision.

Hypothermia

In recent years hypothermia has been introduced as an adjunct in several forms of cardiac, vascular and cranial surgery. It has also been utilized in the treatment of severe craniocerebral injuries. Its value is difficult to assess. It is always easy for the physician to state that the patient was so desperately ill that he would not have recovered without this or that form of treatment, but such a conclusion is most difficult to prove. It is our opinion that actual hypothermia is seldom indicated or of value in cases of cerebral injury, but we believe that on occasion a patient is materially helped by using the technics of hypothermia to lower his temperature to normal or slightly subnormal levels. It must be borne in mind that to lower the patient's temperature to levels very far below normal may interfere with certain metabolic processes and produce problems which would not otherwise exist. The following case will illustrate both the value of lowering the temperature to near normal levels and some of the problems which hypothermia may produce.

Case 4. — A 50 year old man was admitted to the Chicago Wesley Memorial Hospital on Aug. 24, 1958 in a stuporous condition. No history was immediately available. (Sometime later we learned that he had been struck

on the head by an assailant, robbed and beaten on August 23. He was taken by the police to another hospital where he remained overnight only. The following evening a friend found him in a stuporous condition in his apartment. So far as was known, he had formerly enjoyed excellent health.)

Examination disclosed a blood pressure of 185/110 mm. Hg, a pulse rate of 110, and a temperature of 101.6 F. He was unresponsive and uncooperative, but turned himself from side to side. The neck was very stiff. The pupils were equal and reacted to light. There was a slight left lower facial weakness, and Babinski's sign was present and the abdominal reflexes absent on the left side. There were no other localizing neurological findings.

A lumbar puncture revealed a grossly bloody cerebrospinal fluid under normal pressure. Within 12 hours the temperature rose to 104 F. and the blood pressure to 210/130 mm. Hg, and the blood sugar was elevated to 530 mg. per hundred cubic centimeters. As he was receiving glucose intravenously, this finding was, however, difficult to evaluate, but insulin was added to the intravenous fluids.

The following day he was less responsive. The temperature rose to 104.6 F. Hypothermia was instituted with a refrigerating blanket. The temperature was dropped to 88.5 F. (31 C.), and he was given Thorazine to control his shivering. The blood pressure fell precipitously to 80/60 mm. Hg, and had to be elevated and maintained by the administration of Vasoxyl (methoxamine hydrochloride). Whenever the systolic blood pressure fell below 80 mm. of mercury, excretion from the kidneys ceased. In spite of the administration of insulin the level of glucose in the blood did not fall, and there developed a severe acidosis with a carbon dioxide combining power of 12.1 mEq. and four plus acetone in the urine. There was marked hyperpnea. Sodium bicarbonate was given intravenously. A tracheal tube was inserted, and large amounts of mucus were aspirated. Great difficulty was encountered in maintaining the blood pressure and urinary excretion. The blood sugar rose to 670 mg. per hundred cubic centimeters in spite of large amounts of insulin. Auricular fibrillation developed.

On August 26 the body temperature was raised to normal and maintained there. A normal cardiac rhythm was restored, but the rate remained rapid. The systolic blood pressure was maintained at about 100 to 120 mm. Hg, with Levophed. In the next 24 hours the level of glucose in the blood was lowered to about 170 mg. per hundred cubic centimeters, and the patient began to respond, first to painful stimuli and then when spoken to. The urinary output rose to 100 cc. in 12 hours. On August 25 he had been given 125 units of insulin; on August 26 he received 450 units, on August 27, 20 units, on August 28, 130 units, and either 30 or 40 units a day thereafter.

On August 27 he murmured a few words. Levophed was discontinued. The following day he was much more alert. By this time it was no longer necessary to use the hypothermic blanket to maintain the patient's temperature in a normal range. He was taking fluids well by mouth and he was replying in short sentences. On August 29 he climbed over the siderails of his bed and went to the toilet. On September 4 he was allowed up and walked well. On September 9 he was able to read a newspaper and to engage in intelligent conversation with his friends and business associates. He learned to administer his own insulin and was discharged from the hospital on September 19. He has continued to do well except for an episode of atrial fibrillation in February 1959.

An x-ray examination of the skull made just before he was discharged from the hospital revealed a long linear fracture of the skull in the left temporoparietal area. This confirmed the information which we received tardily that he had been struck over the head.

DISCUSSION.—This interesting and unusual case illustrates both the benefits and dangers of artificially lowering the body temperature of a patient with a severe craniocerebral injury. It appears likely that lowering this man's rapidly rising temperature at a time when his condition was deteriorating progressively was a life-saving measure, but producing a hypothermia resulted in severe complications. It interfered with his glucose metabolism making control of his diabetes impossible, and throwing him into a severe acidosis; it and the administration of Thorazine were associated with a severe arterial hypotension in a hypertensive patient, and this in turn caused an anuria. Restoring the temperature to a normal level and maintaining it there greatly simplified the medical management and led to a surprisingly rapid and complete recovery. It now seems obvious that this man suffered from a craniocerebral injury with a linear skull fracture and an intracranial hemorrhage.

Electroencephalography and Angiography

In recent years electroencephalography has been utilized in the diagnosis of many neurological conditions. There are many situations to which it has been applied where it is not of particular value. Craniocerebral injury is one of these. In fact, its use in this field to date has produced more confusion and more error than it has brought help. Electroencephalography may demonstrate abnormalities in the differences in electrical potential which it records in some cases of craniocerebral injury. The one situation in which it might be most useful is the diagnosis of subdural hematoma, and it is in this condition in particular that it is likely to fail us. In our experience electroencephalography seldom provides data which are of value in the management of patients with craniocerebral injuries, or in the evaluation of the nature and extent of their injuries.

Cerebral angiography will demonstrate a subdural hematoma beautifully, but in cases in which a subdural hematoma is suspected, it is usually as simple to make bilateral burr holes in the skull which not only will confirm the diagnosis but will often supply adequate treatment. It is well, however, for every neurological surgeon to be aware of the angiographic picture typical of a subdural hematoma as he may see one when he does not expect to.

Conclusions

In concluding let me again remind you that the most important thing to remember while caring for a patient with a craniocerebral injury is that the outstanding symptom of cerebral com-

pression is a progressive worsening of the patient's state of consciousness and of his contact with the world about him. When that occurs, do not delay; take steps to relieve the compression of his brain. Remember that traumatic intracranial collections of blood or fluid may be bilateral or multiple on the same side.

Compound fractures should be promptly treated by removing contaminated and foreign material, by closing the opening to the outside whenever possible, and by the adequate and prolonged administration of antibiotics.

Depressed fractures of the skull usually should be elevated.

In comatose patients an adequate airway should be assured and the accumulation of fluids in the hypopharynx and trachea prevented. Tracheotomy is often a life-saving procedure.

Avoid the excessive and prolonged use of depressant drugs such as barbiturates and paraldehyde.

Spinal puncture should be used whenever it is indicated, but not routinely.

Dehydration, whether with urea or some other agent, is not a panacea. In fact, it is of value in only a very few cases. Its prolonged use may be dangerous.

Surgical decompression, also, has been found disappointing in many cases. Operation should be reserved for those cases in which there is a definite indication.

Hypothermia may prove to be a valuable adjunct in a few carefully selected cases. In general, hypothermic technics prove of greater value when an elevated temperature is lowered to normal levels rather than when a hypothermia is produced.

Electroencephalography is seldom of value in the diagnosis, treatment or evaluation of craniocerebral injuries.

Angiography may prove of great value on occasion, especially in some cases of subdural hematoma, but does not have widespread application to these cases.

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Labor's Concern With Medical Care And Medical Insurance

James Brindle
DETROIT

I am very glad to be here and to speak to the Florida Society of Internal Medicine. I am pleased that you want to hear from a representative of labor about the ideas and problems we have with medical care and health insurance. I note that last year you were addressed by Albert Whitehall of the Health Insurance Council. I know Mr. Whitehall and I am also a personal friend of Ed Faulkner, who is President of the Health Insurance Council. You will find that I have a substantially different viewpoint on health insurance and on the provision of medical care than these men. But, at this point in the development of America's health insurance, we must be prepared to deal wih a wide range of ideas and to discuss a good many different viewpoints.

Divergent Views

Basically, there are three distinctive points of view: (1) that of the provider of services; (2) insurers—although between types of carriers there is often substantial variation; and (3) institutional buyers—representatives of employers and of labor unions who, I might add, have a growing interest in what is offered for sale as health insurance and the medical care it covers. We must find a method by which the views of these three groups can be synthesized so that we may develop a generally satisfactory health insurance system. This third group, which is relatively new to the field, institutional buyers, will be of growing importance. You might call us sort of customers' agents. There are growing numbers of such people in the labor field; they have their counterpart in major business.

Activities

Let me tell you about my job. I work for an International Union, the United Auto Workers, with 1,200,000 members working in auto, agricultural implement and aircraft plants and for suppliers to these industries. I head the Social Security Department, a technical consultative agency of the Union, which has on its staff insurance experts, actuaries, economists and other technicians. We are active in collective bargaining for pensions, insurance, unemployment benefits and health service programs.

Each of us on the staff is engaged in activities outside the Union. We lecture at colleges, at medical schools, before national organizations and we work with professional organizations. I have served on committees and addressed organizations representing medicine in many parts of the country, as have several of my colleagues. One of them, Jerome Pollack, this week spoke to the Annual Conference of Blue Cross and Blue Shield Plans in Los Angeles. Another appeared on a Symposium on Health Insurance at Washington Medical College in St. Louis. Earlier this week I addressed the American Academy of Obstetricians and Gynecologists in Cincinnati. We get around.

We work with the officers and staff of the Union on national and state legislation and we are active in professional associations. This year, I am Chairman of the Medical Care Section of the American Public Health Association and am a member of its Committee on Medical Care Administration. I also serve locally as a Director of the Area Hospital Council and am the vice president of a community hospital.

In the programs for which the Social Security Department provides technical advice, we spent in collective bargaining during 1959 about $375 million. In the field of health insurance alone, premiums on collectively bargained programs ran to $130 million. This is big business with us. You should know, too, that the UAW works with community programs. It has practically no welfare funds and no union-operated programs like those in the garment workers and other labor organizations. Very early, as a matter of conscious policy, the UAW chose to go the community program route and has consistently backed Blue Cross and Blue Shield. We are very active in these organizations throughout the country.

Director, Social Security Department, United Auto Workers.
Read before the Florida Society of Internal Medicine, Jacksonville, April 10, 1960.
Editor's Note: Mr. Brindle's address is published at the request of the Board of Governors of the Florida Medical Association and the Florida Society of Internal Medicine.

There is something else about collective bargaining that too many people misunderstand and which I would like to touch on briefly. No matter whether payment for a health and welfare program—for pensions, insurance, or prepaid health care—comes from company funds or is checked off and paid for by the worker, it is still the subject of collective bargaining. When the union sits across the table from a major employer and decides that a certain level of benefits and certain types of programs will be adopted in collective bargaining, the cost is a clear allocation from wages. When union members decide to spend another 5 cents per hour for health benefits in a collective bargaining session, this is a straight out deduction from wages, and union people know this.

Voluntary Health Insurance Growth

America's voluntary health insurance system has had a tremendous growth in the past 20 years. It now covers something like 70 per cent of the population or about 130 million people. It has increased tenfold in the last 20 years. In 1958, premiums paid under the voluntary health insurance system in the United States amounted to over $4½ billion. And this is a fivefold increase in 10 years. No one originally anticipated this rapid and tremendous growth. Early founders of Blue Cross thought that within 10 years Blue Cross might cover five million people. Actually, in terms of the people covered, the development of voluntary insurance has gone far beyond the fondest hopes of its early proponents.

The numbers covered are thus very impressive, but the extent of coverage is far less so. If you look at over-all figures for private health expenditures in the United States, only about one fourth of the cost is covered by insurance. For those insured, only one third of the cost goes through the insurance mechanism. By categories of care, a little over half of the general hospital care is insured and something around one third of physicians' services.

We have heard the opinion expressed at times that insurance has gone too far and that more payment should be out-of-pocket at the time the care is provided. However, for those of us who are attempting to purchase care, the present coverages seem inadequate. We believe improvement is indicated. I am not suggesting prepaying all private health care. But, I do think that we should look forward in the next few years to running coverages from something around a third to something around two thirds. This is not too ambitious an objective for our economy or our insurance system.

Problems Encountered

Of all the programs for which I am responsible, we have the most trouble with health insurance. Here are some of the problems that our membership has with commonly available hospital and medical insurance: First, and probably most important, is the fact that despite substantial insurance coverage, very many people must, at the time of serious illness, pay sizeable medical bills. The second negative feature, so far as union members are concerned, is that premiums have been rising rapidly and continually. The third objection has to do with the organization and control of insurance and of medical care.

I have in my office the following documents: A bill for surgical operation on the wife of a UAW worker. The charge for the operation is $150; the amount allowed by Blue Shield, $100; the balance, $50, for which the doctor asks payment. This $150 fee was set by the physician on the basis of a Blue Shield schedule that had just been superseded by a higher one. When the doctor's bill went to Blue Shield, they told him he was entitled to $135 instead of $100 for the operation. The better coverage was negotiated on and agreed to between the employer and the union, because we thought the higher schedule would reduce the amount that people had to pay extra for surgery. A few days later, the worker received an amended bill. The charge for the surgical operation had been raised to $185. The new higher amount allowed by Blue Shield was shown as $135, and there remained a "please remit" request for the same amount—$50. In other words, the union and the employer, who shared in the cost of the new more expensive coverage, got nothing for their money.

On a statistical basis, we know of another situation where a schedule of allowances for surgery was increased on the average $26 per procedure. However, extra charges were reduced only $6. The extra dollar spent through premiums was really worth only 23 cents.

This idea of charging extra, over and above insurance, is doing immeasurable harm to the medical profession. It creates tremendous resentment—way out of proportion to its monetary value to most physicians. Moreover, even where

service programs are promised, they are often not honored. One study in Michigan indicated to us that about 67 per cent of those whose income was below a $5,000 income ceiling actually had to pay extra. Yet, Blue Shield and the local Medical Society were receiving very few complaints about overcharging. It is my studied opinion that the profession hurts itself much more by overcharging than any possible value its members can get out of it. And it is my strong recommendation that you find some way to put a far less slippery price tag on the cost of medical care which is covered by insurance.

Incidentally, the new Florida $5,000 family income ceiling program, for which premiums were increased by a very substantial amount, does not meet the needs of an auto worker whose annual income runs a little over that $5,000 figure. I think this figure is also a little too low for most other industrial employment. It is my suggestion that the medical profession abandon income ceiling schemes and try to develop schedules and programs that will be fully paid. This would be of tremendous help to the insurance industry and to your own chosen carrier, Blue Shield.

Inflation Factors

A second important consideration is the inflation of cost which has been steady and spectacular. Hospital rates, for instance, lead every other item on the Consumers Price Index. We recognize that improvements in medicine and the upgrading of hospital employment in terms of hours of work, salaries and working conditions all justify substantial increases in the cost of hospitalization. And, we do not want to see physicians underpaid. As a matter of fact, we are perfectly reconciled to generous compensation for physicians who have, literally, life and death responsibilities thrust upon them every day. But we are concerned when too little attention is paid to some of the elements that go into continually increasing cost. And we should recognize, too, that health care costs are increasing not only on an absolute basis, but as a percentage of disposal income.

A study of hospital use in Michigan by Blue Cross, with the cooperation of the State Medical Society, indicated that something around one fifth of the hospital-bed days are not indicated medically. My own observation indicates that this figure underestimates, rather than overestimates, the amount. I think it could easily run to one third. Now, I recognize that it is difficult to make rules to keep people out of the hospital and that physicians could do medical violence to their patients if they rigidly restrict hospitalization. But I submit that if we are paying something like one third higher than we should in premiums for hospitalization in the United States, we should be able to squeeze out some of the water before we raise rates again.

There have been other elements more prominent in the past than they are at this point which made for unnecessary inflation of health insurance. There was early evidence of a substantial amount of unnecessary surgery. I pretend to be no expert in this field; I cite Dr. Paul Hawley's pronouncements and other evidence which have hit the press on occasions. I know of one very early study, when prepayment was first developing in Michigan, where appendectomies among those insured were six times more frequent than among those who did not have coverage. A discrepancy like this cannot be easily explained away. I should say in all justice that the latest figures published by the Society of Actuaries indicate a very substantial reduction in appendectomies, tonsillectomies and hysterectomies. To me, this is a good sign. And last week, I heard Dr. Kenneth Babcock, who heads the Joint Accreditation Commission, express satisfaction at this. Actually, I think, this is in large measure due to the fact that hospital staffs are exercising more control over surgery.

For a while, it was anticipated by the insurance industry that major medical would arrest inflation in medical insurance. In 1956, Jerome Pollack, who works with me, predicted very accurately the outcome of major medical. He felt that too much was being expected of a purely economic mechanism to control care and he said then that it would be necessary to operate other controls if drastic inflation was to be arrested. And he predicted fees would be unduly inflated if fee schedules were abandoned. In his work on the West Coast, Jerry has just run into an instance of the kind of gross inflation that has taken place under many major medical plans. At Douglas Aircraft, in three months after a major medical program was installed, surgical fees charged by physicians increased 17 per cent. Except for two major carriers, which seemed to have done a good job of operating their claims examinations and have worked directly with the profession to hold down fees, most major carriers are losing

money or drastically increasing premiums. In the instance that I cited in relation to Douglas Aircraft, benefits ran almost $2 million higher than premiums last year.

There really was no good reason to anticipate that major medical would work effectively as an instrument to arrest the inflation of health care. And, in my mind, there is very grave doubt whether economic controls like deductible and coinsurance, which characterize major medical offerings, can possibly be effective. Moreover, they are subject to serious questions from a medical point of view. For instance, when a person is inhibited from going to a physician by these fiscal controls, what is there to assure that he does not need medical attention? As is coming to be realized, the patient himself is a very poor practitioner, and any internist worth his salt will want to see a person early in the course of illness.

There is another area of increasing cost which is related to one of the difficulties the internist finds himself in. This is the income levels of the various medical specialties. Early insurance offerings, Blue Shield as well as the commercial insurance, were largely concentrated in the field of surgery. Benefits for medical practice, as contrasted with surgery, are almost uniformly low. The inequity persists. To my mind, present insurance patterns shortchange the internist. However, it is not likely that by negotiations inside medicine you will get a reduction in surgical fees, so that more money can be afforded to internists. What may be feasible is to arrest the increase in surgical fees and upgrade some of the other specialty payments so that income is more rationally determined. It is very difficult to make the distribution of the health insurance fee schedules equitable from a medical point of view. About the only place where this is successfully done is in group practice, where the group divides the income on an objective basis relating to training, ability and the contribution each practitioner makes. But to do this in an open market fee-for-service scheme is practically impossible. Nevertheless, some of the inequities can be remedied.

Some practitioners in certain specialties seem to be building up exorbitant incomes. In radiology, anesthesiology and pathology, there is a drive to move to a fee-for-service or share of income basis in instances where for a long period these specialists worked on salary. Certain leaders in these specialties now actually seem bent on an economic venture which would cancel out a large number of reasonably satisfactory arrangements with hospitals that have existed over long periods of time. These specialists who work in hospitals enjoy a distinctively superior bargaining position. They use expensive equipment supplied without cost to them. They maintain fees at the noncompetitive level of other similar specialists who work in their own offices. They have a near monopoly on referrals. And, by refusing to cut fees, they thereby substantially enhance their income. Actually, I think the whole case for the adequate and equitable compensation of physicians can be set back if the public comes to realize the inordinate take of certain specialists. And, I think, before too long a Congressional Committee will begin to look at this problem. Again, let me stress, I am for adequate compensation for physicians, but I do not think the practice of medicine was designed to build a fortune; it was to save and preserve life. It should, of course, produce a well above adequate income.

It would seem essential to discuss matters of medical economics frankly and not to introduce concepts of ethics that are not relevant to the subject. For far too long, we have mixed up fee-for-service with the doctor-patient relationship, and solo practice with quality. If we disentangle ethics from compensation and organization, we can discuss them more rationally.

Quality Safeguards

The most important area of deficiency in presently operated health insurance and medical programs is in the matter of quality and the controls that insure quality. You are beginning to find labor people supporting measures which guard and preserve the quality of care. Probably one of the most graphic illustrations of the need for medical scrutiny of health care is exemplified in a statement by Dr. Warren Draper, Medical Director of the United Mine Workers Welfare and Retirement Fund. He made this assessment:

> . . . . organized medicine, while insisting that it alone possesses the authority to judge and discipline its members, has thus far been unable or unwilling to establish and enforce effective means of doing so.

Dr. Draper, in the exercise of his responsibilities for annual expenditures of almost $60 million from an employer-union Trust Fund, did what he felt was necessary to correct the situation. He added:

> As data accumulated, it was evident that in many places surgical diagnosis and operative surgery for

Fund beneficiaries were inferior in quality, and the amount of surgery was far in excess of that performed on others. This was confirmed by qualified surgical consultants who reviewed the records at our request or examined our patients at medical centers to which they were transferred.

The Fund began to exercise some controls with the following results: Hospital admissions were cut by more than 32 per cent. Rates for all surgical procedures were reduced by 16½ per cent and for appendectomies by almost 60 per cent.

We had something of a similar experience, without the implication of lack of quality, in Kenosha, Wis., where with American Motors we found we were in for very heavy expenditures under our health insurance program. The incidence of hospitalization, especially for medical admission, in that area was substantially above average. We got together with the Corporation and called in the County Medical Society and the hospital administrators to discuss this very high incidence. After some discussion, the expenditures dropped to some extent, and we are trying to develop a continuing fruitful relationship.

In our mind, controls and the organization of medical care are key features, not only in providing for economy, but in assuring the quality of service. Health insurance needs direct medical controls, and the medical profession should make itself responsible for operating them. I believe that there are convincing examples that the organized profession in almost any community can do a good job of assuring reasonable economy and protecting the quality of medical care.

As an example, I cite the experience of the San Joaquin Medical Foundation developed by leaders in that California County Medical Society. The Foundation, while not administering prepayment itself, takes responsibility for medical scrutiny and supervision of any health insurance program that a group in the community wants to carry, if they will abide by rather simple rules of the Foundation. Any county society could take this kind of responsibility for the control of medical care.

On the other hand, there are organizational frameworks in which it is not so difficult to handle the matter of control. I cite here the Kaiser Foundation Health Plan in California. Consistently, the incidence of hospitalization in this program runs little more than half of that in Blue Cross. A tremendous amount of work is done on an outpatient rather than inpatient basis, and the physicians, in groups, related to hospitals, have no motivation for unnecessary hospitalization. Moreover, patients are encouraged to come early with symptoms of illness and are treated promptly.

In Detroit, because of dissatisfaction with the existing Blue Cross, Blue Shield and commercial insurance programs, the United Auto Workers is backing the development of a community prepayment plan, the Community Health Association, which will attempt to provide a full range of medical care benefits—home and office care, rehabilitation, preventive services as well as medical and surgical services in the hospital and hospital care itself. The Board of the new agency, which is comprised of community leaders (there are only three labor representatives on the board of 15), intends to offer this service on an individual free-choice-of-plan basis, not only to auto workers but to other organized and unorganized groups in Detroit.

Better Organization and Control Essential

Let me stress that I am not sure, nor are others in organized labor, precisely the way in which medical care ought to be organized and controlled. We do feel, however, that better organization and better scrutiny of medicine are an absolute necessity. We will be completely satisfied if efficiencies, economies and protections can be exercised adequately by the medical societies. At this point, we are not convinced that without the development of competitive plans, official medicine will act vigorously enough. The fact that Kaiser Plan offered stiff competition in California, we believe, is the reason why the Medical Foundation plan began to develop. It is our feeling that if we can develop competitive closed panel group practice programs in major cities, we will get better Blue Cross and Blue Shield. We will get better health insurance. We think, by this method, organized medicine can be encouraged to step up to its responsibilities and exercise the kind of control over health insurance that is absolutely necessary if our voluntary system is to survive.

And, I believe that voluntary health insurance in the United States can survive. I believe that we can be the first major industrial country which does not turn almost wholly to goverment for the bulk of its health insurance coverage. We have the resources. We have the ability. But we certainly need to work at the job. We should not blind ourselves to the fact that there are serious, and possibly fatal, defects in the health insurance

programs that we now have. We must all address ourselves to developing better health insurance.

Physicians can depend on the growing number of informed people in labor for support in developing better voluntary prepayment plans. We must sit down and work out detailed programs that meet the needs both of labor and of medicine. Personally, I have worked with the Michigan Medical Society and the Wayne County organization. I have worked with Committees of the American Medical Association. I spend a lot of time talking to groups like yours. We have union members on Blue Cross and Blue Shield Boards. We are doing everything possible to make the voluntary system work.

If we have a strong voluntary system, no one will be able to sell Americans on turning further to government. Nothing the labor unions are doing, in terms of political and social action, will bring about the nationalization of health care. If it happens in America, it will be because people are not satisfied with what voluntary insurance can offer.

Health Care for the Aged

Just one further word on this subject. The medical profession is one of the major forces operating against the extension of Social Security into the field of health care for older people. This, to my mind, is an area where government action is needed. And I feel strongly that we should use our government where it serves better the needs of Americans. It is a democratic government, responsive to the wishes of the people. It is not a bureaucratic dictatorship. I would feel much more comfortable about our future in health insurance if we could get away from the idea that any extension of government help constitutes a foot-in-the-door to the universal socialization of medicine. As a matter of fact, "socialized medicine" as a phrase is losing its zip. A few years ago, the use of this phrase stopped all progress in the field of the selective use of government to prop up the voluntary health system. The day has come when this scare phrase has probably lost its potency.

I sincerely wish we could sit down together in harmony—and work out some mutually satisfactory way by which the aged in America could be assured reasonably adequate health care. I am convinced that this could be done without violating any valid tenet of medicine. I know we are in strong disagreement on this point at this time, but I look forward after legislative action, which will surely come, to working out a satisfactory way to integrate our voluntary and our governmental system. This is the strength of America. We have learned to be pragmatic. We have learned to use the voluntary way when it is superior, but we have not been afraid in the long run to call in government when this is the instrument that best serves the will and the need of the people.

Again I say that the voluntary health insurance system in the United States will survive if we work very hard at improving it. And, if we do develop a vigorous voluntary health insurance system, the American people will support it.

8000 East Jefferson Avenue.

Gavage-Emesis
A Rapid and Efficient Method Of Emptying the Stomach in Poisonings

O. DAVID SOLOMON, M.D.
ST. PETERSBURG

The emergency room procedure in cases of acute poisonous ingestion has been rather stagnant for decades. Although the literature contains many papers covering the statistical aspects of the problem and others covering the problem of poisonings in general, there is a paucity of detailed information about the most important line of treatment in these cases—Gastric Evacuation.

With but few exceptions, it is commonly advocated that poisonous gastric contents should be removed as quickly and efficiently as possible. This line of treatment is certainly logical and physiologically sound, but how well is it usually carried out?

Present Methods

The victim of an ingestion of poisonous material is usually fully conscious when he arrives in the emergency room. Often the specific poison ingested is not known; therefore, the process of emptying the stomach is begun. Mechanical stimulation of vomiting reflex is sometimes attempted. This procedure may be all the treatment that is essentially necessary, provided the patient has (1) a sensitive vomiting reflex and (2) an adequate volume of gastric contents that can act as a diluent and "vehicle" for the removal of the poison. The failure of this method to provide adequate gastric emptying is usually due to the absence of one or both of these conditions. Frequently the gastric contents are minimal at the time of ingestion of the poison. Because of this lack of "vehicle" in the stomach, vomiting becomes an ineffective method of removing the poison.

The induction of vomiting by such home remedies as "warm soapy water" may be an entirely satisfactory method of obtaining gastric emptying. Occasionally, however, one encounters a person who vomits immediately on swallowing this unpalatable solution. The ingested fluid then does not serve satisfactorily as a diluent and "vehicle." On the other hand, some persons will not vomit on drinking such emetics. Ipecac is usually effective if a sufficiently high dose is used. The difficulty with this drug is that the onset of action is extremely variable. Often the physician finds he cannot afford to wait for ipecac to take effect and resorts to other methods for faster action. Ipecac alone may produce retching without adequately removing the poison because of the lack of "vehicle." Mustard water, potassium and antimony tartrate and copper sulfate, like ipecac, have the disadvantages of uncertainty of action and a long latent period.[1]

The best vomiting agent is apomorphine. Excellent results are possible when the stomach contains a sufficient volume of "vehicle" to remove the poison. Here again, the difficulty may arise from the lack of "vehicle" and vomiting may not effectively get rid of the ingested poison.

Most writers[2-5] advocate the use of gastric lavage for the removal of poisonous gastric contents. This method eliminates the problem of sufficient "vehicle" to dilute and carry out the poison. Additional problems, however, are inherent in this method of gastric evacuation. The first obstacle is the insertion of a gastric tube, especially one of sufficient size to permit the passage of food particles. In children and uncooperative adults it is most difficult to get the patient to take a large gastric tube through the mouth. It usually becomes necessary in such cases to pass a small Levin type gastric tube through the nose. Lavage with such a small bore tube is invariably inefficient if the stomach contains recently ingested food. The tube becomes plugged by food particles, and the stomach becomes filled with irrigating solution as less material is withdrawn from the stomach than is introduced into it. The procedure is always time-consuming—a decided disadvantage to the busy emergency room physician.

Harstad, Moller and Simesen[6] studied the technique of gastric lavage in poison victims, both living and dead, and in dogs. They found that 24 per cent of the lavage fluid is not returned, and that after lavaging with 10 liters, less than one half of the poison is removed. By the use of radiopaque lavage fluid, *roentgenograms showed the fluid had passed to the cecum during the lavage procedure.*

Gavage-Emesis Method

The method for emptying poisonous gastric contents advocated here is a combination of gastric gavage and emesis. Vomiting is induced with subcutaneous apomorphine after neutralizing solution has been given by gavage. Once vomiting has begun, continuous gavage is carried out. This technique has the following advantages over those previously mentioned:

1. "Vehicle" is not a problem
2. Emesis is effectively brought about
3. A small gastric tube is used
4. The tube is never plugged by food particles
5. The method is fast
6. Constant attendance by a physician is not necessary

Technique In Detail

If the patient is a child, "mummify" him with a sheet wrap, then tape him to the table after a gastric tube is passed (fig. 1).

Pass a Levin tube through the nose into the stomach and tape it securely in place.

Give apomorphine subcutaneously, 5 mg. for adults, and 1 mg. for children. The leg is accessible if the child is mummified.

Place the patient in the prone Trendelenburg position with the head lowered over the end of the table.

Connect a Kelly bottle to the gastric tube (fig. 1) and allow the gavage fluid (water or neutralizing agent) to flow freely into the stomach.

Do not give more than 500 cc. of fluid (proportionately less in children) unless vomiting occurs. Apomorphine may be repeated once after 15 minutes.

When vomiting begins, continuous flow into the stomach is permitted. About 1,000 to 3,000 cc. of wash fluid is usually sufficient to cleanse the stomach thoroughly.

Give universal antidote, or specific antidote, and 10 to 15 Gm. of magnesium sulfate in water by gavage after vomiting stops.



Fig. 1.—Gavage-emesis technique. The poison victim is "mummified" and taped to the table. The table is in the Trendelenburg position. A Levin tube is taped in place; it enters the stomach through the nose. A Kelly bottle containing gavage fluid is connected to the Levin tube.

Clamp the gastric tube and then withdraw it.

Dangers

The gavage-emesis treatment is contraindicated in patients who are not sufficiently conscious to avoid aspirating vomitus. In poisonings by sedatives, apomorphine should be withheld because of its central depressing action. In such cases one ounce of ipecac is added to the initial 500 cc. of gavage fluid. When vomiting begins, the technique is carried out as before. If ipecac fails to bring about vomiting, mechanical stimulation of the vomiting reflex should be tried. If all measures fail to bring about vomiting, gastric lavage must be undertaken and continued until the return fluid is clear.

Corrosive poisons could weaken esophageal and gastric walls, making perforation during intubation a serious threat. Procedure in these cases should be carried out with great care.

Kerosene poisoning should be treated by gavage-emesis only after tracheal intubation to prevent aspiration.

It might be well to mention the areas of possible danger in the gavage-emesis procedure. One must be certain that the gastric tube is in the stomach before beginning gavage. The tube must be taped securely in place to prevent the tube from slipping out. In addition, the attending nurse must continually check the position of the tube. The patient must be face-down to avoid aspirating the vomitus.

Report of Two Cases

C. L., aged three years, and G. L., aged five years, were brought to the emergency room with a history of ingestion of 95 grain aspirin tablets. The time of admission was 3 a.m., and the emergency room staff consisted of one registered nurse, one nurse's aid, and a physician. Both children were "mummified" with sheet wraps and quickly intubated. The gavage-emesis technique was carried out using bicarbonate solution with good results. The vomitus of C. L. was clear while G. L.'s vomitus was compatible with an ingestion of 95 grain aspirin tablets. Magnesium sulfate solution was given after emesis had ceased.

Both patients were admitted to the hospital overnight for observation. They were discharged the following day without symptoms.

These cases are reported to bring out the usefulness of the gavage-emesis technique in busy emergency rooms with a limited number of personnel.

Experience with Gavage-Emesis

The gavage-emesis technique of gastric evacuation has been employed by me in 21 cases at Mound Park Hospital over the past 12 months. Nineteen cases were those of poisonings in children, and two were in adults. In this series there were no complications nor untoward effects resulting from the procedure. There were no fatalities in the group.

Summary

A method of gastric emptying, especially useful in poisonings in children, is described. The method involves induction of emesis by apomorphine along with continuous gastric gavage. This technique has decided advantages over the other methods of gastric evacuation, namely: (1) a small gastric tube is used; (2) the tube is never plugged by gastric contents; (3) effective vomiting is brought about; (4) the stomach has adequate liquid to dilute and carry out the poison; (5) constant attendance by a physician is not necessary; and (6) the method is fast.

A series of 21 cases is reported in which this method was used successfully. Two of these cases are described.

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Fatal Hemorrhage From Duodenal Ulcer Associated With Portal Cirrhosis, Chronic Myelogenous Leukemia And Right Renal Cell Carcinoma

Samuel W. Page Jr., M.D.

MIAMI

Rapidly exsanguinating hemorrhage of the upper portion of the digestive tract constitutes a taxing medical emergency in every instance. When a past history is unavailable or scanty and unreliable, the situation is even more difficult. The following report of a case testifies concerning the complexity of possible contributing factors and the danger attendant upon the formation of premature conclusions.

Report of Case

The patient was a 59 year old white man. Little could be learned about his past health record except for a history of long term alcoholism associated with inadequate dietary intake. No history of serious injury, illness, or surgical operation was obtained. The present illness began with diarrhea, followed within 24 hours by passage of tarry stools in large volume, restlessness, anxiety and weakness. He was sent promptly to the hospital after examination disclosed pallor, sweating, tachycardia and both hepatomegaly and splenomegaly.

On admission, the pulse was 95 and regular. The blood pressure was 120 80 mm. Hg. At this time he was restless and confused. Physical examination confirmed the initial impression concerning enlargement of the liver and spleen, and revealed scattered "spider" hemangiomata in the usual locations of the upper part of the chest, the arms and the neck. No lymphadenopathy was detected. No other abdominal masses were palpable, and there was no tenderness. Ascites could not be detected, nor was there visible icterus. Body hair was scant. The remainder of the physical examination was unremarkable.

The initial hemoglobin level was 6.1 Gm. per hundred cubic centimeters. Treatment included immediate measures to combat shock, two units of whole blood, morphine, and atrophine. Vital signs remained stable during the remainder of the night. In the morning, the hemoglobin level was still 6 Gm., and the red blood cell estimate was 2,160,000 per cubic millimeter. The white blood cells numbered 71,200 per cubic millimeter, with 5 per cent basophils, 2 per cent basophilic myelocytes, 17 per cent premyelocytes, 7 per cent juvenile myelocytes, 26 per cent stab forms, 42 per cent mature myeloid cells and 1 per cent lymphocytes. Platelets were estimated to number 64,800. Bleeding time was two minutes 10 seconds. Coagulation time was four minutes 35 seconds. Prothromblin time was 18.4 seconds (control, 12.9 seconds). Cephalin flocculation was three plus at 24 and 48 hours. Urinalysis gave normal results.

Barium swallow roentgen study was deferred because of the critical condition on the morning after admission. The patient was extremely restless, agitated and uncooperative at this time. Gastroesophageal tamponade was not attempted. All agreed that surgical exploration was not compatible with survival. Terminus occurred 36 hours after admission despite intensive therapy with oxygen, blood transfusions and supportive measures.

Necropsy revealed that death had resulted from massive bleeding from an eroded artery in the base of an acute duodenal ulcer (fig. 1). Extensive portal cirrhosis was observed, with approximately 300 cc. of intraperitoneal fluid. Gastroesophageal varices were not demonstrated. Chronic myelogenous leukemia was present with rather widespread tissue infiltration, most pronounced in subendocardium (fig. 2), adrenal, lung (fig. 3), liver (fig. 4), and brain, where recent hemorrhage into the left parietotemporal region was seen. In addition, a small renal cell carcinoma was present in the right kidney (figs. 5 and 6).

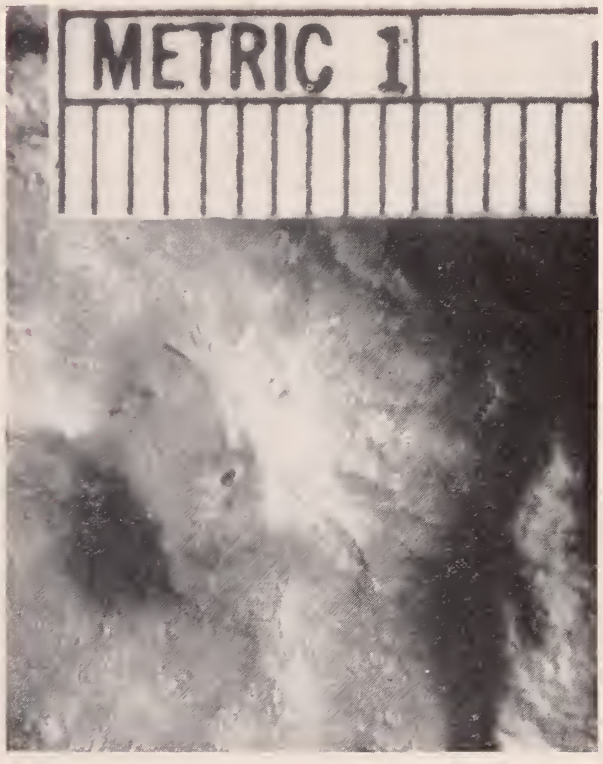


Fig. 1.—Eroded artery in duodenal ulcer.



Fig. 2.—Heart showing leukemic infiltration.

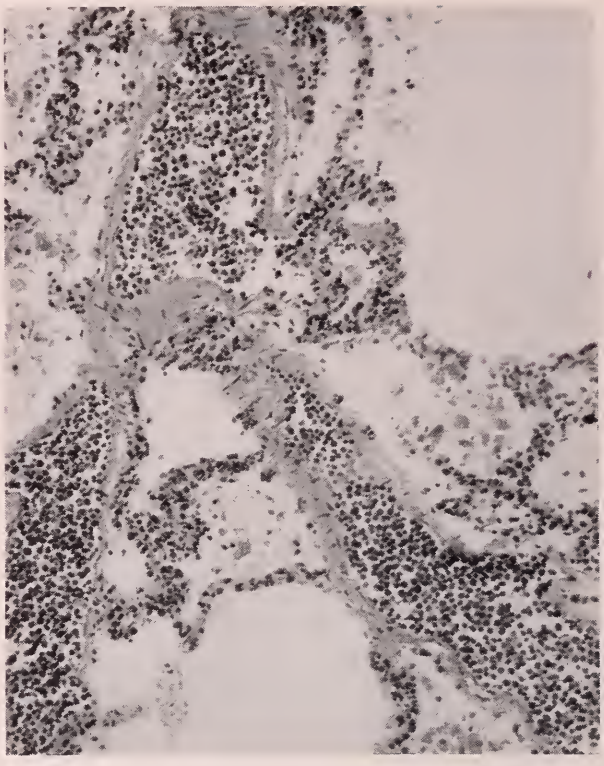


Fig. 3.—Lung showing leukemic infiltration.

Discussion

It has been estimated[1] that peptic ulcer causes from 60 per cent to 75 per cent of the bleeding of the upper portion of the digestive tract. Serious hemorrhage may take place in 10 per cent to 20 per cent of patients with ulcer, while occult bleeding probably occurs in at least 25 per cent. For unknown reasons this complication is rare in women. Contributory factors may include alcoholism, physical and emotional stress, arteriosclerosis and hypertension, infection, dietary factors, and certain pharmaceutical agents, notably corticotropins, steroids, and aspirin. Superficial erosions, not radiographically demonstrable, may account for as much as 15 per cent of the bleeding of the upper portion of the digestive tract. Early roentgen examination may prove to be extremely helpful if a possible causative lesion can be demonstrated in cases of serious bleeding of unknown origin.

Many experienced observers have concluded that the coexistence of cirrhosis and peptic ulcer is altogether coincidental and of no clinical significance.[2-6] Others have been impressed by a higher incidence of peptic ulcer in patients with cirrhosis, although they are unable to offer explanations for an actual cause and effect relationship.[7-9] Local hyperemia may occur in portal hypertension, adversely affecting tissue resistance and predisposing to ulceration. The general deficiency state which is often associated with cirrhosis might well contribute to reduced local resistance and retard natural healing as well. Regardless of possible etiologic relationships, these

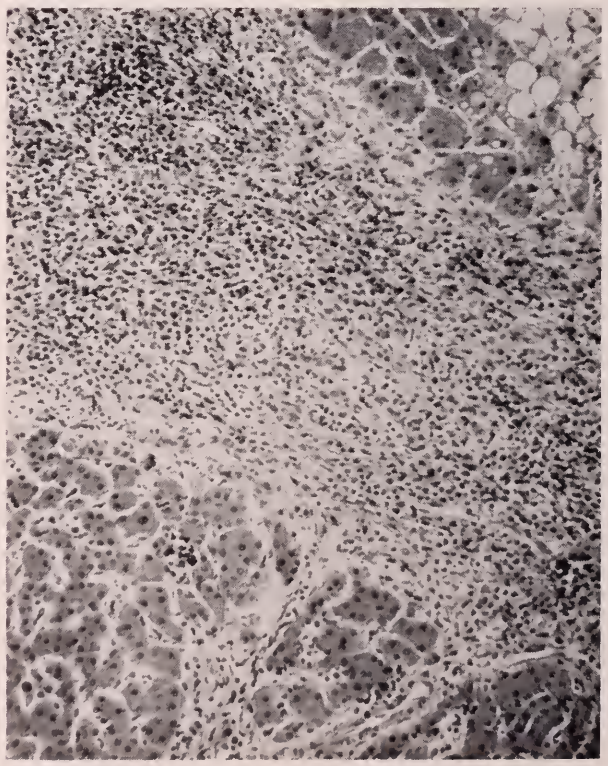


Fig. 4.—Cirrhosis of the liver with leukemic infiltration.



Fig. 5.—Renal cell carcinoma of the kidney.

factors, and others less obvious, may well have highly significant effects when massive hemorrhage occurs.

The relationship between cirrhosis and leukemia is discussed by Greer[10] and by Taylor,[11] who suggest that coincidence alone explains the coexistence. The case here reported offers no other answer.

The adverse effects of leukemia upon spontaneous hemorrhage and upon the control of bleeding during and after surgery are well known and have been described and partially explained by many.[12-18] The influence of leukemia in this case is questionable since it is rare to observe bleeding in leukemia in the absence of thrombocytopenia below 30,000. The prolonged prothrombin time in this case was undoubtedly due to the cirrhosis.



Fig. 6.—Renal cell carcinoma of the kidney with leukemic infiltration.

The occurrence of diffuse reticuloendothelial malignant disease and a focally located malignant lesion may seem didactic, but it must be remembered that a patient with chronic leukemia or lymphoma may have five, ten, or more years of productive life if no other threat arises. It is extremely important not to consider and interpret the signs and symptoms of a potentially curable, independent, focal, malignant lesion as part of the generalized disease. While reports of such coexistence suggest rather wide disparity of observed incidence, the fact and the obligation to bear it in mind persist.[19-23]

Summary

Peptic ulcer should always be considered as a probable cause for bleeding of the upper portion of the digestive tract in patients with portal cirrhosis. Early diagnosis and immediate surgical treatment may be life-saving. Successful management of this acute emergency depends entirely upon teamwork by internist, surgeon, house staff and nursing staff, with the assistance of a dependable laboratory and a well supplied blood bank. In this case, the coexistence of chronic myelogenous leukemia may have influenced both the course and the outcome. An immediate barium swallow with nonmanipulative roentgen examination might have demonstrated the ulcer in this case, and such information could have influenced the decision concerning surgery. Hindsight, unfortunately, cannot tell what the outcome would have been if operation had been elected. It is unlikely that the renal cell carcinoma would have been detected in its early stage unless hematuria had led to appropriate investigation.

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Leroy E. Burney, M.D.
Washington, D. C.

It is a particular pleasure for me to be with you this morning on an occasion which celebrates an important stride forward, not only in the lives of all of you who are receiving degrees, but also in the life of your university and your state. With the graduation of its first medical class, the University of Florida establishes yet another claim to membership among the distinguished ranks of state universities which serve the many and diverse needs of their citizens.

This is a day to remember for all of you who are receiving your diplomas. Yet it must hold for you medical and nursing graduates a certain special increment of pride at being among the first physicians and nurses to call this university's medical school your Alma Mater. You are the founders of a new tradition, blazers of a trail for many others to follow. Whatever changes may come in the constantly changing world of medicine within the constantly changing world at large, you will have been the pioneers.

The idea that Change is the only Constant has been expressed in hundreds of ways by thousands of poets, philosophers and commencement speakers since Biblical times. For me, one of the most provocative statements of this eternal truth was made by the former English Poet-Laureate, Robert Bridges, who said it this way:

> Our stability is but balance. Wisdom lies
> In masterful administration of the unforeseen.

I am going to suggest this morning that for all of us, in this space-probing, atom-piercing world, our stability is the stability of a plane in flight, which must maintain forward motion to remain airborne. There is safety only in moving with the times. Further, the measure of our wisdom and our success, regardless of our training or profession, will lie in our skill as administrators of the unforeseen.

Involvement in Mankind

In this age of statistical projections, motivational research and electronic brains, it may seem mildly heretical to talk of the unforeseen. We like to believe, and sometimes we almost succeed in persuading ourselves, that nearly everything is predictable now, and absolutely everything soon will be. And yet our daily experience with such disparate events as political elections and disease outbreaks reminds us that we still view the future "through a glass darkly."

Let me give you an example, drawn from my own experience.

Everyone old enough to remember World War I has an anecdote to tell about the terrible influenza pandemic of 1918, known generally as the "Spanish flu." When the final toll of this disease had been counted, its victims — some 20,000,000 around the world, perhaps 850,000 of them in the United States—far outnumbered those killed on the battlefields. Mankind had not suffered such an onslaught since the black plagues of the Middle Ages. The United States has never experienced its equal, before or since.

Now let us roll the calendar forward to a similar event within the memory of everyone here—the Asian influenza epidemic of 1957. This pandemic was unforeseen and unforeseeable, in terms of its date, point of origin and precise nature, just as its predecessor had been.

Nevertheless, machinery which had been set up in the interim swung rapidly into action. Within a month after the disease broke out in Red China and then in Hong Kong, the virus strain was isolated by personnel of a U. S. Army Field Hospital in Japan and identified by the Walter Reed Army Institute of Research in Washington as a new strain, against which the general population had virtually no immunity. By the end of this same month of May, drug manufacturers had begun developing a vaccine, and vaccine was available before the first case occurred in our country.

The Asian influenza epidemic struck the United States in full force in September. At its peak, it was estimated that as many as 12 million Americans were confined to bed during a single week in late October. Viewing the epidemic in retrospect, however, there is little doubt that the massive preparations prevented a far more serious result. Sixty million doses of vaccine had been produced in six months—a remarkable achieve-

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Surgeon General, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.
Commencement Address, University of Florida, Gainesville, June 6, 1960.

ment—and those persons who received the vaccine soon enough obviously received a large measure of protection.

I have told this story in detail, not for purposes of self congratulation to the health professions, but rather to illustrate a process—the process of drawing on the known and the predictable to deal effectively with the unknown and the unpredictable.

The Asian influenza story is illustrative also of another essential to success in the present world —cooperation across a broad range of disciplines and skills. At first glance, combating an influenza epidemic may appear to be strictly a medical problem involving the so-called health professions. But the list of the people and groups involved ranged all the way from news editors and TV commentators to the poultry farmers who supplied millions of fertilized eggs needed in the manufacture of the vaccine. Finally, and most important of all, it included the people everywhere who made the personal decision to be vaccinated.

The moral of the story is that there is no such thing as a one-dimensional problem in our time. Everyone is in the health business, just as everybody is in the defense business and the community development business. All of us are—in John Donne's beautiful phrase—involved in mankind.

Present Trends

Let us turn now to a brief consideration of those trends which are foreseeable in our dynamic and developing society, and problems which will stem from these trends. As I point out the health implications of these general problems, I hope you will bear in mind that not just the medical graduates, but each of you, will be involved in these problems and must help to find the solutions.

At least four unmistakable and accelerating trends shape and condition much of the life of the American people today. Their influence is felt on our health and on almost every aspect of living.

The first of these is the rapid growth of our population. Since I began speaking a few minutes ago, the Nation's population has increased by at least 40. Not just 40 babies born, but 40 more people—excess of births over deaths. By the time you graduates return for your first class reunion next June, the Nation will have added more than two and a half million people—about as many as there were in the whole State of Florida in 1950. By 1975, your fifteenth reunion year, there will be 40 million more Americans than there are today.

The second great fact of contemporary American life is the growth of the metropolis. Already almost two thirds of us live in 185 metropolitan areas. Most estimates indicate that by 1975, three fourths of us will be city dwellers. We can already see supercities forming along the Atlantic seaboard from Portland, Maine, to Norfolk, Virginia; along the Pacific from San Francisco to the Mexican border; along the southern shores of the Great Lakes and down the Ohio River Valley. Here in the South, the same tendencies are plainly visible.

The third factor shaping our lives is the almost unbelievable expansion and diversification of our industrial machine. Today we are dealing with processes and products which, although they are taken for granted by most of you, were unheard of before World War II. Synthetics, plastics, detergents, insecticides, high energy fuels, drugs, food additives—the list could be extended indefinitely without even mentioning the soaring future of nuclear technology. To a greater degree than ever before, we are living in a man-made environment.

Almost 100 years ago, Henry Adams stated: "Man has mounted science, and is now run away with. I firmly believe that before many centuries more, science will be the master of man. The engines he will have invented will be beyond his strength to control. Someday science may have the existence of mankind in its power, and the human race commit suicide by blowing up the world."

All of us fervently hope that Mr. Adams' predictions are too pessimistic. But we are forced to admit that, to date, our success in creating new products has not been matched by parallel progress in controlling the possible harmful effects of their production and use.

Finally, we are living in a world so compressed that the health and well-being of our most remote and primitive neighbors on the globe have a direct, palpable impact on our own lives. A recent experience of mine dramatized for me the truth of the old truism about a "small world." I left Cairo, Egypt, on a Friday afternoon and arrived in New York on Saturday afternoon, having spent a night and half a day in London en route. Think of the staggering problems that have been over-

come to make such a trip possible, and the tremendous implications for the present and future.

These forces—population growth, concentration in cities, industrial expansion and the shrinking world—interact to produce the challenges confronting all of us, in every profession, today. And the problems are so interwoven in the fabric of American life that it is impossible to treat them separately as "health problems" or "educational problems" or "economic problems."

Basic Challenges

One problem of the present and future is the Nation's shortage of trained and educated manpower. The dramatic appearance of the first Sputnik in October of 1957—less than three years ago—shocked the United States into a reappraisal of our scientific manpower situation. Since that time there has been impressive progress in our dealings with the macrocosm and the microcosm —with outer space, and the space inside the atom.

The high drama of space probing and atom piercing has tended to obscure no less urgent needs for manpower in the prosaic middle ground in which we live and breathe. We are beginning to feel the pinch in medicine and its allied sciences as a result of the population explosion, plus greatly increased use of medical services *per capita*. Your fine new medical school here in Gainesville must have many newer counterparts across the Nation if we are to keep pace with the need.

It is clear that communities can expect increasing numbers of patients of all ages with long term illnesses. Few, if any, existing patterns of institutional care are geared to this problem. And the situation is further complicated by the changing face of the metropolis. Most hospitals and other health facilities are located in the central city, and many of them are now surrounded by urban deserts of expressways and parking lots, while the people they were established to serve have moved to the suburbs, taking their tax money with them. At the same time these metropolitan areas are a tangled jungle of political and administrative units. State, county, city and township agencies deal separately with the problems they share in common, not only in health but also in traffic circulation, law enforcement, and dozens of others. Too often, people seem to be more interested in "who's in charge" than in getting the job done.

We have discussed two of the basic challenges of our time—serving more people, and developing new patterns of service. The third challenge which I should like to touch upon briefly is really the extension of these two beyond our own borders—the challenge of service to the world.

I have just returned from Geneva, where I had the privilege of serving as chief of the United States delegation to the Thirteenth World Health Assembly. There my colleagues and I discussed mutual problems with leaders in the health professions from the renascent nations—countries rich in tradition and history but young in self government, eager to have for their people the benefits of modern science—and also with representatives of countries whose health record is fully as good as ours and in some respects even better.

As always in international meetings of this kind, I was impressed not only by how much we have to give but also how much we can receive through wholehearted cooperation with our neighbors on the earth. I was reminded again of the familiar slogan, "The life you save may be your own," which has profound significance for us as citizens of the United States whenever we consider our participation in the world conquest of communicable diseases. A couple of years ago a smallpox epidemic broke out in Heidelberg, Germany, introduced by an infected person who arrived from Madras, India. The outbreak was contained, thanks largely to the worldwide surveillance network of the World Health Organization. But the moral is clear. On a small planet, where oceans are spanned in hours, a gain in health anywhere is a gain for everyone.

Your own State of Florida, as our gateway to the Caribbean and Latin America, has repeatedly shown that it understands this problem well. And your accomplishments in health, and in many other fields, in a natural environment similar to that of many other nations, are a shining demonstration of what can be achieved. Only a few years ago, malaria was still a name to be feared in this Southeastern region. Today it is gone; and many countries in both hemispheres are presently following our example.

It has been said facetiously that the future isn't what it used to be. I like the joke, but disagree with the implication. The future in all fields holds higher expectations than at any previous moment in human history. These expectations will be realized in proportion to our skill in administering the foreseen and unforeseen.

The J. Hillis Miller Health Center

The establishment of the great new Health Center here at the University of Florida exemplifies the processes which are indispensable to success.

First, it was well and thoroughly planned. Dr. Miller, the distinguished educational statesman whose name it so fittingly bears, said in 1952: "The worst thing in the world is to establish a poor medical school, which can so easily happen if, in its establishment, we do not first assess the health needs of the state and the need for adequate physical facilities in order that the school will meet the specific health problems of our people." The long and careful planning period which preceded the development of the Center has yielded a rich harvest.

Second, it is the product of a balanced partnership among the many economic resources with which our country is blessed.

Third, it combines in one integral whole the many disciplines and skills essential to the practice of medicine and the preservation of health. Your College of Health-Related Services, by its very title, marks your recognition of the new era in which we live. Ours is a time in which important contributions to health knowledge come from research in the physical sciences, on the one hand, and the behavioral sciences on the other; and in which health knowledge is applied in the community through the efforts of persons and groups who seemed totally unrelated to health a few short years ago. Your teaching hospital and clinic marks your recognition that medical education, medical practice and medical research are indivisible. The Health Center as a whole covers the entire range of curative, preventive and restorative medicine.

Fundamentals Plus Extras

I have every confidence that each of you who receives his diploma from the University of Florida today is well equipped with scientific and technical knowledge, and—more important still—that you are prepared to add to this store of knowledge and skill through the coming years. These form the indispensable foundation for success in any calling.

I hope that you will also carry with you through your careers a few of the extras which are the difference between competence and leadership.

To my mind, one of these is adaptability. Knowledge can be acquired and applied "by the book," and because the "book" has been so well prepared by our predecessors, it is possible to perform satisfactorily in this way. But if your grasp of your work is of a different kind, you will be able to improvise, to find new ways of applying old knowledge to new situations. Your skills will be tools adaptable to the changing challenge.

Another of these extra added ingredients is a range of interest across the entire spectrum of human activity, which permits you to see your specialty and your profession in relation to the society with which it interacts. We in the health professions are compelled to recognize that the basic decisions affecting health are made, not by specialists in our own field but rather by the people of the Nation and the world. Many of them are economic and social decisions, and health is only one of a multitude of factors that enter into their making.

Finally, I hope you will carry with you a sense of adventure. The new frontiers are many, and each holds its own intrinsic drama. There is the research frontier—the urgent need for new knowledge. There is the community frontier—the quest for new patterns of service whereby all the resources of the community are dedicated to the effective and efficient application of knowledge on behalf of all the people. There is the international frontier—bringing to those nations which exist side by side with us the benefits which we have realized.

The Three C's

Someone has said that the purpose of education is not the "three R's" but the "three C's:" competence, curiosity, and conscience. Your years of study in this great institution assure you a certain degree of competence, and I am sure you recognize that learning is a never-ending process, so that your competence is not complete but only well begun.

I am confident also that your educational experience here has stimulated your curiosity, encouraging you to think, to give full play to your imagination, to explore new ideas and show a healthy skepticism about old ideas. We have plenty of facts in this world of ours. To administer the unforeseen we need more ideas, not more facts. Goethe has said: "It is always better to say right out what you think without trying to prove anything much; for all our proofs are only variations of our opinion, and the contrary-minded listen

neither to one nor the other." Setting aside the somewhat cynical tone of this observation, the truth remains that it is well to have ideas and to express them, nonconformist though they may be.

The third requisite, conscience, is more difficult to define and almost impossible to teach except by example. It includes courage of your convictions, blended with humility. It involves tolerance of ways and thoughts which are not yours; an open mind, ready to accept the best from any source; an attitude of rational receptiveness rather than antagonism to new ideas.

And it involves leadership in and beyond your own community, the acceptance of an active and not a passive role. Leadership does not mean imposing your will on others, but rather a willingness to work with others toward a goal worth achieving.

I salute each of you who are graduating today on your successful completion of this all-important phase of your life. And, to a certain extent, at least, I envy all of you the point in time at which you are embarking upon your careers. Starting from our present high plateau of development, you can lead the way to heights above and beyond our present imagining.

ABSTRACTS

Removal of Linear Scars. By John J. McAndrew, M.D. A. M. A. Arch. Dermat. 80:227-228 (Aug.) 1959.

A method of removal of linear scars is described which can be carried out as an office procedure. The author finds that the results compare favorably with those of more elaborate methods. While the method is not new, the surgical principle involved is not mentioned in dermatology textbooks and is not sufficiently known to dermatologists. The seven steps required are described.

Five and Ten Year Follow-up Study of Rheumatic Patients. Role of Climate and Environment. By Milton S. Saslaw, M.D., F.A.C.C., F. A. Hernandez, M.D., F.A.C.C., and Hazel Ellen Randolph, M.A. Am. J. Cardiol. 3:754-757 (June) 1959.

How the important factors of climate and environment affect the recurrence rate and long term outcome of rheumatic disease was investigated in Miami, where the climate is tropical and favorable. A report is here made on five and 10 year studies completed on 102 and 48 expatients of the National Children's Cardiac Hospital in Miami to determine whether or not the lives of these subjects were influenced by a period of convalescent care in this tropical area. Data were available on 92 of the five year group and 41 of the 10 year group of patients. In the total 133, the death rate was less than 7 per cent. Of the 124 survivors on whom there was information, 16 per cent had recurrences. Cardiac damage, more than minimal, was observed in only 31 per cent of the 124 survivors. The death rate, frequency of recurrences and the cardiac damage all compared favorably with similar reports from other centers.

Simplified Measurement of Pulmonary Function in Office Practice. By L. P. Carmichael, M.D. GP 20:130-132 (Nov.) 1959.

Satisfactory assessment of pulmonary function has been a difficult and time-consuming process, usually unavailable to the general physician. A simple, relatively inexpensive, portable apparatus is here described by which the physician in his office may determine the vital capacity, timed vital capacity and maximum expiratory flow rate. A permanent record is obtained which may be compared with the patient's previous graphs to evaluate the course of his disease and the response to therapy. The usefulness of such a machine extends to virtually all diseases of the cardiorespiratory system. Tracings are shown to illustrate the use of the machine in several conditions, and especially to demonstrate its value in objectively following the patient's progress.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Our Poor Relations

Just as, the saying goes, every family has its poor relations, the family of medical practitioners also has its poor relations—too many of them. They are not the kind that have to be assisted financially, but are for sure the kind that ought to be kept hidden in the family closet. I refer to our public relations, those which we as individual physicians bear toward the public as individuals and as a group.

All the efforts of organized medicine, the American Medical Association, go for naught in this field in picturing for the public an image of the physician as a benign, interested, self-effacing, dedicated healer and medical counselor when individual physicians live and practice as hardhearted, pompous, self-aggrandizing, money-grabbing misanthropes.

The low status to which we have fallen in the eyes of the public in the last few generations as compared to the position of trust and respect which was once our traditional, endeared place in the hearts of the community is in largest measure due to the carelessness with which we conducted ourselves, our poor rapport, our lack of communication. How many of us are guilty of being curt, short-tempered, unreachable, impatient with patients who are perhaps a little demanding, thoughtless, and in some instances not physically ill but in need of counsel and reassurance?

In these troublous times for the profession, when we move from crisis to crisis without fully settling any of them, rarely to our own satisfaction, when we keep fighting rear guard actions and find ourselves giving a little ground here and a little there in an effort to stave off completed capitulation to the desires of self-styled do-gooders and bureaucrats in government and other administrations with whom we must constantly deal, it behooves us to dress up the face we turn to the public, our patients. This is not a suggestion that we act a part we do not sincerely feel, lest we be accused of having ulterior motives only, but that we turn over new leaves, if necessary, that we earnestly and in all humility come down off our high horses and behave as true disciples not only of Hippocrates but also of the Great Physician.

Leo M. Wachtel

THE JOURNAL
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Three's a Crowd

Most of us are fond of such generalizations—just as we are fond of traditions—routines—and stereotyped channels of thought and action. Within limits, the adoption of them is wise, safe, and usually reliable, inasmuch as the tried and true methods—the surviving and traditional patterns—are generally based upon broad, if empirical, foundations. But insofar as our adherence to these ideals, customs and mores of another generation is secondary to lassitude and indolence—insofar as we accept sweeping generalities, protocol and tradition, simply because we are too intellectually lazy to pursue logical and promising avenues of investigation—then, certainly to this extent, we are guilty of bad habits.

In this Journal is reproduced the talk given by Mr. James Brindle, of the United Auto Workers Union, to the Florida Society of Internal Medicine. Here is a careful and forceful expression of a problem by one who speaks for a sizeable portion of America. Whether or not we agree with his principles, we must accept the fact that his is a very clearly developed philosophical idea to which his organization, and many like it, are committed as a practical solution to the problem of medical care. This is an entirely different approach from that made by these same organizations 10 years ago, when they clamored for Government Medicine. Perhaps this is *still* what they want—and at present they are merely approaching it by a more devious and circuitous route. Perhaps they are not sincere when they say that voluntary health insurance can be the answer to the problem. This each of you must decide for yourself—from reading their statements and from talking to them. Certainly Mr. Brindle impressed most of us with his dedication and desire to secure effective medical coverage for his group, on a financially sound basis, without exploitation of the Physician or forfeiture of any advantages accruing from the traditional Physician-Patient relationship.

This activity, however, makes it clear that the ancient romance between Physician and Patient has been disturbed by the presence of a third party chaperon; and if, indeed, three is a crowd, it is probable that we are destined to live in crowded conditions during the foreseeable future. Let us recall that crowds need direction. Certainly the two of us in the front seat will remain ever conscious, during our moonlight ride, of the passenger behind us. All this, of course, simply

emphasizes our growing acceptance of a paternalistic concept in government. Proponents of Mr. Brindle's philosophy have developed the theme that, if indeed, Local and Federal Governments, as well as Unions, are to treat their constituents as the minor children of a large family, then, indeed, they have the responsibility of providing shelter, food, medical care and other essentials—and luxuries—for individuals unable to fend for themselves. From this they reason that, if such children are unable or unwilling to insure adequate medical care for themselves, the agency undertaking this procurement—and financing it—should have some voice in the type, the quality and the availability of the service. And although it has been argued that we all pay the bill—through taxes—still it is difficult to maintain that no one, other than the Physician, should exercise any control over the quality of service rendered, and that the patient cannot assign this supervision with the responsibility of procurement. And so we return to a much larger principle—to socialism and central government, on the one hand; and free enterprise and individual responsibility, on the other. Here is the problem of Social Security to which many Physicians eagerly subscribe. And if, indeed, this be the will of the land—then it is our obligation as citizens, as well as Physicians, to accept it, but simultaneously to raise our voices in protest against those principles which we deplore, and to persuade others of our convictions. And certainly we should explore—with vigor, enthusiasm and acumen—all possible solutions to the medical care problem as complicated by this third party which has now come to live with us—solutions by which we may provide service through a united effort of the profession itself, retaining the free choice of Physician among the self-policed competent members of organized Medicine. With proper planning, thought and experimentation, we can do this.

In our situation, admittedly, three is a crowd—yet I am certain that we have the ingenuity to surmount this obstacle—just as I am certain that, throughout the ages, the duenna has never posed an insurmountable problem to the ingenuity and the energy of the eager señorita and her ardent escort.

J.W.A.

Dialysis for Renal Disorders

Extracorporeal and Intracorporeal Technics

In 1913 Abel, Rountree and Turner[1] published the first description of an artificial kidney. In describing the procedure they stated that "there are numerous toxic states in which the eliminating organs of the body, more especially the kidneys, are incapable of removing at an adequate rate the natural or unnatural substances, the accumulation of which is detrimental to life." Since then numerous technics have been used to perform the excretory function of the kidney. None has been completely satisfactory. No method, of course, in any way incorporates the selective reabsorptive properties or metabolic functions of the kidney.

Most artificial means for clearing the body of accumulated substances utilize a semipermeable membrane* which is interposed between the patient's blood and a properly constituted rinsing fluid. Cellophane is generally used in extracorporeal technics such as the artificial kidney. Intracorporeal methods differ in that a membrane of the body, for example the peritoneum, is used. In either case the membrane is readily permeable to water and to crystalloids of smaller molecular weights. Molecules of larger molecular weights such as albumin and protein are generally retained in the body. The cellophane membrane is inert; the peritoneal membrane for the most part functions as if it were inert. The rate of solute transfer, therefore, depends upon the concentration gradient of the crystalloid as well as diffusion characteristics of the substance.

Experience with both extracorporeal and intracorporeal technics has repeatedly demonstrated that only two salutory effects can be expected:

I. Correction of certain abnormalities of the composition of body fluids, including:
   1. Hyperkalemia
   2. Acidosis

*Exchange resin columns are being evaluated experimentally as a technic for extracting unwanted molecules.

3. "The Uremic State"
4. Intoxication by ingested agents

II. Removal of fluid

Both technics are useful only as temporary measures in the treatment of acute renal failure (where the renal lesion itself is eventually reversible) or in cases of acute intoxication due to ingested agents. The procedures are only rarely useful in the treatment of chronic renal failure.

The methodology has been greatly improved and simplified since Abel described the first artificial kidney in 1913[1] and Putnam[2] in 1923 described the potentials of the living peritoneum as a dialyzing membrane. The Kolff twin coil kidney, in comparison with other artificial kidneys, is relatively easy to set up and operate. Prepackaged cellophane units are commercially available.[3] Doolan and his associates[4] and Maxwell and his associates[5] have revived interest in intermittent peritoneal lavage, and necessary tubes and fluids are available commercially.[5] Utilizing the principles of the siphon the solution may be readily drained from the peritoneal cavity after equilibration has occurred. The procedure is technically quite easy to carry out.

Both extracorporeal and intracorporeal technics can remove significant quantities of excessive "natural or unnatural substances." The time required to accomplish the same results by the two methods varies, however. Doolan[3] has stated that approximately 10 two hour peritoneal dialyses are required to remove as much urea nitrogen as will be accomplished with one five to six hour hemodialysis. Experience with both technics in this clinic would corroborate this observation.

In this clinic use of the artificial kidney and peritoneal dialysis are considered complementary rather than supplementary procedures. Of the two, peritoneal dialysis is less costly and technically easier to perform. Elaborate equipment and constant supervision by highly trained personnel are unnecessary. It is the safer procedure for use in infants and children. Utilization of the artificial kidney results in a more rapid correction of abnormalities of body fluids. It is more efficient in treating acute intoxication due to ingested compounds. Both procedures are effective in removing excessive fluid; however, experience in this clinic would suggest that peritoneal dialysis is the more efficient in this regard.

Unlike extracorporeal procedures, intracorporeal technics do not require donor blood or anticoagulation and do not result in hemolysis or predispose to thrombophlebitis. Peritoneal dialysis, on the other hand, is always accompanied by the potential hazard of peritonitis. It must be used cautiously in patients with recent abdominal surgery or widespread adhesions and is contraindicated by peritonitis or hiatus hernia.

Regardless of the type of artificial dialysis that is used, it should be considered an adjunct to rather than a substitute for well planned, conservative therapy. Neither procedure should be used by persons not familiar with the problems attending fluid and electrolyte balance in anuric or oliguric patients. Physicians with experience in such problems, however, may feel secure in using peritoneal dialysis in community hospitals provided good laboratory facilities are available. Because of the complexity of the procedure, the artificial kidney should probably be used only in centers with a well trained team. The rare patient with rapidly progressive uremia or other contraindications to peritoneal dialysis will, therefore, probably have to be referred to such centers.

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Plans for the Eighty-Seventh Annual Meeting—1961

The scientific program of the Eighty-Seventh Annual Meeting of the Florida Medical Association will follow basically the same plan as the meeting held in Jacksonville last year, Dr. Thad Moseley of Jacksonville, chairman of the Committee on Scientific Work, has announced. There will be three scientific assemblies with the first being held on Friday morning, May 26; the second that afternoon, and the third on Saturday morning.

The program for the first assembly, according to present plans, will consist of two Diagnostic

Panels of one hour each. The details of these presentations will be worked out later.

The Committee continues to plan the second scientific session as that time allotted to presentation of papers prepared by Florida physicians. The final date for submission of abstracts for consideration by the Committee is November 15. It has been requested that abstracts be 25 words or less and that they be sent to Dr. Moseley.

The program for the final scientific session on Saturday morning will feature presentations by guests of the special interest groups and the Association. Arrangements have been completed with five groups to provide the speakers. The Florida Academy of General Practice is searching for the physician best qualified to discuss radioactive substances in clinical medicine. The Florida Pediatric Society has consented to provide a speaker to discuss chemotherapy in children, and the Florida Chapter, American College of Surgeons, has obtained the consent of Dr. Oscar Creech of New Orleans, who is to talk on perfusion therapy in cancer. It is hoped that following the discussions upon each of these subjects, a panel discussion can be held with answering of questions from the floor.

After a short intermission, the Florida Urological Society will present a speaker who will discuss some phase of the kidney's role in hypertension, and the Florida Society of Anesthesiologists is to provide a speaker to discuss anesthesiology in hypertension. With the five speakers, plus a panel discussion, the time allotted to the third session will have been filled, and it is hoped that the group of speakers will present subjects of interest to all the members of the Association.

The hobby section of the Scientific Exhibit, begun last year, will be continued. Physicians who have a hobby or collection which they would like to share with others are urged to use the form published for their convenience in this issue of The Journal. While entries in this section were limited at the April meeting in Jacksonville, sufficient interest was manifested to warrant the continuation of the program, in the opinion of the Committee.

The Eighty-Seventh Annual Meeting will be in the Americana Hotel at Bal Harbour, the north section of Miami Beach. In this hotel, facilities permit the scientific program and all other activities to be presented in the same general area, which should assure excellent attendance.

Hospital-Medical-Insurance Partnership

From a Physician's Standpoint

The majority of the American people have clearly demonstrated that they desire a system of prepaid medical care. It is estimated that the present population of the United States is close to 180 million people. It is also estimated that over 127 million persons are covered by some type of hospital benefits and 118 million persons have surgical benefits. Even though the medical profession may not think it is ideal to have a third party involved in the doctor-patient relationship, it is inevitable that we must bow to the will of the majority of the people. With this premise it is up to the medical profession to help devise a system whereby the American people can prepay medical care and hospital care and still maintain the high standards we have today. In order to maintain the high standards of today, we must continue to engage in research and to develop new methods, new techniques, and new drugs. These goals cannot be carried out unless we continue to have free competition among doctors, hospitals and insurance companies.

Perhaps I surprise you with the statement of free competition among doctors. Doctors begin competing when they apply to medical school. In 1949-1950 there were 24,434 individual applicants to medical schools. In 1956-1957 there were only 15,918 applicants. In 1950-1951, 40 per cent of the students accepted for first year medical school had an A college average. In 1956-1957 only 16.1 per cent of the first year class had an A average. This reduction in applicants and the quality of the applicant is alarming. This change has arisen because there has been a tremendous expansion in the technical need of other sciences, such as electronics, nuclear physics, and chemis-

Presented before the Florida Hospital Association, Tampa, June 16, 1960 at a Seminar sponsored by the Florida Health Insurance Council.

try. As a result, medical schools are having to compete with other science schools in order to attract the bright students. The other sciences are attracting more and more of these young people for several reasons. There has been a rapid expansion in the needs of these new scientific fields. The financial return from these new vocations approaches that of the physician and may even exceed it. Numerous articles have appeared in popular magazines highly critical of the medical profession. We have educated our young people that we should not work more than a 40 hour week. A medical student must work at least 60 hours a week or more during his medical school years, and after medical school the average physician continues to work at least 60 hours per week. The cost of obtaining a medical education and the length of time needed to complete it far exceed that of the other scientific fields. We are going to have a serious health crisis if we do not expand our medical education facilities and attract more men and women into the field of medicine.

After the medical student becomes a doctor, he competes for his postgraduate education, applying for internships, residencies, and fellowships. The young physician entering practice competes with his older colleagues for patients. All of these factors give us a constructive type of competition which makes us better doctors. All of this competition is healthy and it is one of the reasons that under our present system we have the finest medical care in the world. Another important reason for the high quality of medical care available to the American public is the competition between pharmaceutical firms to develop new drugs and between medical manufacturers of x-ray equipment, laboratory equipment and the like, for the development of better equipment, to help us in giving better medical care. If this competitive spirit is destroyed, progress in medicine will become stagnant.

Voluntary Health Insurance

Prepaid medical care must not disturb this healthy competitive spirit and it should be expanded if possible. How then can prepaid medical care best be carried out?

We have many advocates of government medicine among our public servants, social welfare workers, labor organizations, retired groups, and others. We must, however, avoid the pitfalls in Voluntary Health Insurance that would be endemic in government medicine. The system must avoid regimentation of patients, hospitals, and doctors. It is very difficult, for example, to decide fees for hospitalization. In the hospital a doctor is responsible for a patient 24 hours a day. One cannot decide a fee on the basis of hospital visits, for in the care of a hospitalized patient, one must record a complete history and physical examination, write progress notes and discharge summaries for the hospital records, receive phone calls and receive visits from members of the family. All of this is time-consuming to the physician and of no material benefit in the care of the patient. One patient with a coronary thrombosis may require little care from the physician; on the other hand, another patient may have complications requiring hours of the physician's time. It is regimentation to say the fee paid the physician for his time should be the same in all cases of coronary thrombosis.

Some patients because of their economic status want private duty nurses as a matter of convenience. Other patients may require 24 hour individual nursing care.

It is difficult if not impossible to take into account these items in prepaid insurance, unless the patient has some responsibility as to the cost. I believe the pitfall of regimentation can be avoided in prepaid medical care only if the patient carries some contingent liability in order that the patient has an interest in keeping the cost of good medical care at a minimum. For example, in England it was found that millions of pounds could be saved by making a 14 cent charge for prescriptions, thus eliminating the patient's demand for unnecessary prescriptions. The total cost of the average prescription is 70 cents, the government paying the remaining 56 cents in cost.

Any system other than the present system, which is rapidly disappearing, and that is the system of doctor-patient relationship without a third person, has to be more expensive because the mere presence of a third person collecting money from the taxpayers or insurance premiums costs money. The third person paying the patient's bills costs money in clerical help, and in addition, in this already present shortage of physicians the physician must devote less time to his patients and more time to the filling out of forms and doing clerical work connected with the third person paying the fee. Even though this third party system is going to cost more money, the majority of the people are demanding it. We must, therefore, bring to the people's attention that they

must pay a premium over the present cost in order to have prepaid medical care, whether it is done by voluntary insurance or government. I believe that prepaid medical care by voluntary insurance will be least costly and do the least harm to the high type of medical care that we have available for the patient today.

If voluntary health insurance is not successful, I do not believe there is any question in any of our minds that we will have some type of government medicine. It makes no difference whether we use the name socialized medicine, government medicine, compulsory health insurance, or whatever term we use, it is still government regimentation of medicine. It has been proved time and again by comparing either the Veterans Administration or Armed Forces medical care costs with private medical care that in any government form, the expense is greater, and we will not question the quality of the care. The statistical hospital stay for any medical procedure or illness is much longer in a government hospital, and we already have a shortage of hospital beds.

Adequate Liaison

If we accept the premise that the best way to have prepaid medical care is through voluntary health insurance, it is the responsibility of the physician, the hospital and the insurance vendor to make it a success. In order for the program to be successful, we cannot have misunderstandings. The best way to avoid misunderstandings is to have good liaison, and I believe at the present time liaison between the physicians, hospitals and insurance vendors is inadequate in relationship to the problem of prepaid health insurance. The purpose of this meeting today is to aid us in understanding each other's problems, in order that we may work them out to our mutual satisfaction. Four groups are looking at the problem of good medical care from their own standpoint. The patient is looking at it from his standpoint, the hospital administrator is looking at it from his standpoint, the insurance vendor is looking at it from his standpoint, and the physician is looking at it from his standpoint. We must educate the public in our mutual problems and have good liaison with each other in order to make voluntary health insurance a success. We need to conduct an educational program and public relations program as to what volunteer insurance should provide and should not provide.

Use Versus Abuse

The American Medical Association has published the pamphlet "Let's Use, Not Abuse Health Insurance." I wonder how many of you have seen it? Would you raise your hand if you have? I am not surprised that you have not seen it. It is the fault of the medical profession and insurance vendors that the pamphlet does not have wider distribution. It has six pages and is well written; we should see that the public reads it. It should be a must for everyone, especially those who buy some type of prepaid medical care benefits. There are six paragraphs, and their headings are as follows:

> Let's Use, Not Abuse Health Insurance.
> Insurance Doesn't Create Any New Money.
> Insurance Is Designed To Pay Big Bills, Not All Small Ones.
> Why Your Doctor May Not Recommend Hospitalization.
> Know Your Policy—Use It Properly.
> Holding The Line On Medical Costs.

We now hear in our offices each day, "Oh, doctor. I've been paying premiums for years, why shouldn't I get something out of the insurance company?" We must teach the patient that his insurance policy premium is designed only to provide care for him when he becomes acutely ill. If it were designed to pay for diagnostic studies, the cost to him would be greater. I believe that there is a need for policies that cover diagnostic workups, either for a hospital inpatient or preferably for an outpatient in the hospital or doctor's office, where it can be done at a lower cost. Many people are hospitalized under the subterfuge of acute illness for a diagnostic workup and usually the cost to insurance companies will be much greater than if it were done on an outpatient basis. If the patient does not share in some portion of this cost, much needless work will be done. Insurance vendors should explore the possibility of adding certain types of outpatient care to their policies. It behooves the vendors of prepaid medical care to explain carefully to their customers what they are buying when they buy insurance. A few enthusiastic salesmen mislead the patient as to what he is buying. The public may also mislead the salesman as to existing medical conditions. The patient becomes ill and feels he is protected. The doctor sends in an honest report; the patient feels that the doctor denied him his benefits. This type of thing hurts voluntary health insurance—it hurts the private practice of medicine. In order for voluntary insurance to

be a success, the insurance vendor as well as the physician must assume a moral responsibility that the patient has protection at the issuance of the policy, not at the time illness occurs.

We physicians must assume the moral responsibility of avoiding unnecessary hospitalizations and unnecessary days in the hospital. For example, to reduce an average hospital stay for a given illness by one day will save millions of dollars in costs and free thousands of hospital days for care of other patients. If one half of Florida Blue Shield's participating physicians permit one excess day of hospital care for one patient, the daily cost amounts to $60,820. The hospital administrator can also play a very important part in making this partnership a success. Because of the crowded conditions of our hospitals, patients may use up bed space waiting for reservations on operating schedules, or awaiting appointments for certain diagnostic tests. Even with good economy, hospital care is expensive. It is our joint responsibility to show the public why hospital care and medical care are expensive. The average person has no idea of the number of employees required in the hospital, such as orderlies, maintenance men, nurses' aides, record librarians, insurance clerks, and bookkeepers. The average person has no idea what elaborate tests may be made on a sample of blood removed from the arm. He does understand why a house is expensive, why an automobile, or stove, or refrigerator is expensive.

We cannot sit back smugly and say medical care is expensive, and feel no further explanation is needed. We must jointly and individually have good public relations programs in order that the public may understand the difference in medical care today and 20 years ago. The housewife can tell you the difference between her stove of today and the one 20 years ago. The average man can tell you the difference between his automobile today and that of 20 years ago.

In order for the hospital-medical-insurance partnership to be a success, we need to have more meetings such as this one today so that we may better understand each other's problems, medical care from the patient's standpoint, from the hospital administrator's standpoint, from the insurance vendor's standpoint, and from the physician's standpoint. If we learn about each other's problems, I am sure we can find ways to solve them. For example, the American Medical Association and the American Society of Internal Medicine are both individually working on relative value fee schedules. If such schedules can be worked out successfully, it will be of great help to insurance companies in calculating insurance rates.

We have a real challenge. Should we fail, I am convinced we will have some type of regimented government medicine that will do the public a much greater disservice than ourselves. I believe that by close liaison and diligent pursuance of our problems, we will continue to improve medical service to the patient.

Charles K. Donegan, M.D.,
St. Petersburg

Florida Medical Foundation

The Florida Medical Foundation, a nonprofit organization having for its purpose "to promote better medical care in Florida," was established by the House of Delegates of the Florida Medical Association in May 1956. The Charter was approved in September of that year, and the By-Laws were adopted in January 1957. Dr. Edward Jelks of Jacksonville was the first president.

It was necessary to amend the Charter with reference to the objectives of the Foundation in order to obtain tax exemption status. This change was made, and the amended Charter was approved by the Judge of the Circuit Court of Duval County in December 1958. The official ruling from the Internal Revenue Service that the Foundation was exempt from federal income tax and that contributions were deductible was received in January 1959.

The objectives of the Foundation, as revised, are:

1. Improvement of the health and medical care of the people of Florida;

2. Sponsorship of graduate and postgraduate medical education without preference for any person;

3. Aid to persons of Florida needing financial charitable assistance who are pursuing an education in medicine;

4. Aid to deserving indigent or destitute physicians who by reason of illness or mental or physical incapacity need charitable assistance, and

5. Promotion and sponsorship of medical research exclusively for public purposes and benefits.

A Trust Agreement with the Florida National Bank of Jacksonville was executed in February 1958, which has several divisions. Trust Funds

have been set up for the Dade County Medical Association and the Florida Academy of General Practice to administer medical student loans; agreements are in effect with the Florida United Community Funds, Inc., for a medical research program and with the Florida State Board of Health for research and development programs.

At the request of the United Funds and Community Chests of Florida, the Florida Medical Foundation entered into an agreement on Aug. 14, 1959, with the Florida United Community Funds, Inc., to establish the Florida United Community Funds Medical Research Program. This agreement provides that the Foundation will accept such assets as the Community Funds or United Funds donate and transfer irrevocably to the Foundation and will administer such assets for medical research exclusively for public purposes and benefits through its personnel or its Trustee acting for it. Applications for funds to conduct medical research programs will be reviewed by the Committee on Medical Research of the Florida Medical Association and consideration will be given to qualified organizations, groups and individuals including the University of Florida College of Medicine and the University of Miami School of Medicine. The United Funds of Orange County and Broward County have allocated $8,500 to the program for 1960.

The Board of Governors of the Florida Medical Association constitutes the Foundation's Board of Directors. The current officers are Dr. John D. Milton, President; Dr. Alpheus T. Kennedy, Secretary-Treasurer; Dr. S. Carnes Harvard, Vice President, and Dr. Edward Jelks, Medical Advisor. Mr. W. Harold Parham, Executive Director of the Florida Medical Association, serves as Executive Secretary of the Foundation.

Florida Diabetes Association Eighth Annual Meeting Miami Beach, Oct. 27-28

The Eighth Annual Meeting and Seminar of the Florida Diabetes Association will be held at the Balmoral Hotel in Miami Beach on October 27 and 28, 1960.

The speakers will be Dr. Garfield G. Duncan, Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia; Dr. Alexander Marble, Physician, New England Deaconess Hospital, Assistant Clinical Professor of Medicine, Harvard Medical School, Boston; Dr. Roger H. Unger, Assistant Professor of Internal Medicine, University of Texas Southwestern Medical School, Dallas; Dr. A. Gorman Hills, Professor of Medicine, Head of Division of Endocrinology, University of Miami School of Medicine, Coral Gables; Dr. George F. Schmitt Jr., Assistant Clinical Professor of Pharmacology, University of Miami School of Medicine, Coral Gables, and Dr. Joseph C. Shipp, Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville.

The registration fee is $15, and all interested physicians are invited. Reservations for the course may be made by writing the Secretary, Dr. George F. Schmitt Jr., 30 S. E. Eighth St., Miami.

Two Florida Physicians Active in Political Conventions

Among the group of physicians from throughout the country actively engaged in the deliberations of their respective political parties in national conventions during July were two from Florida, Dr. Edward R. Annis and Dr. Ralph W. Jack, Immediate Past President of the Florida Medical Association, both of Miami. Dr. Annis served as a representative of the American Medical Association at the Democratic National Convention held in Los Angeles, and Dr. Jack was seated as a delegate at the Republican National Convention in Chicago.

As a representative of the American Medical Association, Dr. Annis had the opportunity to appear before the committee of the Democratic National Convention drafting the platform which later was to be presented to all the delegates for consideration as the principles upon which the party would base its program provided its candidates are elected at the general election in November.

Mr. Louis Fleming, reporting for the Los Angeles Times of July 6, records the events of Dr. Annis' appearance before the committee:

"A fiery debate over medical aid to the aged broke out yesterday at the opening meeting of the platform committee of the Democratic National Convention.

"The heated exchange of words came during the appearance of Dr. Edward R. Annis, representing the American Medical Association, to urge

the Democrats to refrain from endorsing proposals to finance medical care for the aged from Social Security taxes. He said this would lead to socialized medicine.

"Rep. Ray Madden, a platform committee member from Indiana, broke in to charge the 'brass hats' of the medical association with playing politics for the Republicans.

"Dr. Annis, who said he is a practicing physician in Florida and a Democrat, said vice president Walter Reuther of the AFL-CIO favored the Social Security financing methods as a step in bringing about 'socialized medicine.'

"At this point, president James B. Carey of the International Union of Electrical Workers stood up in the audience.

"'The American Medical Association is not affiliated with the AFL-CIO and it has no right to speak for Mr. Reuther or myself . . . that is a privilege we reserve for ourselves,' he declared.

"Dr. Annis insisted he was quoting from a Reuther speech."

Approximately 10 minutes of oral testimony had been arranged for Dr. Annis before the Platform Committee; however, his time was increased to more than an hour.

Southeastern States 1960 Cancer Seminar Orlando, November 16-18

The nation's top authorities on cancer, three of them directors of the country's largest research centers, make up the faculty of the Southeastern States Cancer Seminar to be held in Orlando on November 16, 17 and 18. The physicians, surgeons, pathologists and radiologists are the most outstanding array of medical talent ever assembled in the South. Each man is a specialist in his field. Each has an international reputation.

On the program are such authorities as: Dr. John R. Heller, President of Sloan-Kettering Institute, New York City; Dr. George E. Moore, Director of the Roswell Park Memorial Institute, New York; Col. Frank C. Townsend (MC), Director of the Armed Forces Institute of Pathology, Washington, D. C.; Dr. Alexander Brunschwig, Professor of Clinical Surgery, Memorial Center for Cancer and Allied Diseases, New York City; Dr. Lyndon E. Lee, Chief of the Extra-VA Research Division, Washington, D. C.; Dr. George Crile Jr., Head of the Department of General Surgery, Cleveland Clinic, Cleveland, Ohio; Dr. Oscar Creech Jr., Chief of Surgery, Tulane University School of Medicine, New Orleans, La.; Dr. Oscar Auerbach, Senior Medical Investigator, Veterans Administration Hospital, East Orange, N. J.; and Dr. Louis M. Orr, Immediate Past President, American Medical Association, Orlando. Each man will speak on his particular specialty, spotlighting the Seminar's theme, "New Horizons of Cancer Research and Therapy."

Already in the mail are personal invitations to more than 9,000 doctors throughout the South from the Seminar's chairman, Dr. Cecil Butt, a pathologist of Orange Memorial Hospital, Orlando. The Seminar is sponsored by the Orange County Medical Society through the cooperation of the Florida State Board of Health and the American Cancer Society. Reservations may be made by contacting the Seminar office, 17 Lake St., Orlando.

PHYSICIAN'S HOBBIES

Fly Tying

"Fishing is one of the few ways left for us to relax in this world of high pressure living; so go fishing to relax and live longer."

G.V.

The development of the art of tying flies was no miracle. It took place quite naturally. Many hundreds of years ago people discovered that fish could be caught by attaching certain colored objects to fish hooks. Patience was a factor in the olden days because of the very crude methods employed. Today fishing with a fly is an easy, active sport packed with thrills and excitement. The improved materials in flies together with improved methods of their construction make catching fish a certainty and a pleasure.

Fly fishing is one of the most successful of all types of fishing because through the long years many different materials and various methods were tried in the construction of lures that would catch fish. We of the present day enjoy the results of those years of experience and experimentation.

One of the greatest thrills of the sport is to play a bass or trout as he leaps in the air, dives, dashes and tugs in his fight before you land him. You have never experienced the greatest joy of



Dr. Jarrell's flies as shown at the Association's 1960 Annual Meeting.

fly fishing until you have caught a fish on a fly which you actually made yourself.

Fly casting for the wily trout or bass is a recreation unsurpassed. It is no wonder, then, that a vast number of vacationists and health seekers are taking up fly fishing as their chief pastime. The thrills of no other outdoor sport can compare with playing and landing a scrappy game fish. No one can know the boundless pleasure that Mother Nature has in store for him until he slips away to some good, quiet stream and matches his skill with the strength and cunning of a big bass or trout. If you are successful in landing him, it makes you proud and satisfied. If he gets away, it thrills and excites you, making you doubly determined to get another one. You will always remember those that got away better than those you caught.

Fly fishing, if only for a day or two, is so stimulating, so reviving, that many people proclaim it the most invigorating and healthful of outdoor sports.

If you would have a wholesome and beneficial vacation, if you would know the boundless, exhilarating joy of fly fishing—then take a rod and some flies, go to a beautiful little stream and fly cast.

Fly tying is recognized as one of the finest tonics for frayed nerves. This is evidenced by the fact that our government has spent hundreds of thousands of dollars for fly tying materials for compulsory use by veterans in government hospitals.

Every fly fisherman will recognize the advantages of making his own fly rod lures. By tying your own, special requirements of your particular locality can be met, and individual preferences can be expressed only if you tie your own. It should be kept in mind that there are very few, if any, prominent fly fishermen who do not tie their own lures.

WALTER G. JARRELL, M.D.
JACKSONVILLE

Note: This is the second in a series of discussions of various hobbies being enjoyed by physicians in Florida. These articles are published in the hope that those physicians who do not have a hobby might be encouraged to begin one, and for those who do have a hobby, these remarks may be a source of interest. The Committee on Scientific Work would like to know about your hobby for possible display at the next Annual Meeting. The blank published in this issue of The Journal on page 278 is for your convenience.

In Acute Illness... NILEVAR® Can Speed Recovery

"Commonly, negative nitrogen balance[1] occurs during acute febrile illnesses and following traumatic events and surgical procedures." As much as 300 to 400 Gm. of nitrogen[2] may be destroyed daily in severe infections. Convalescence[1] is delayed when negative nitrogen balance is large and persistent.

NILEVAR Builds Protein, Speeds Convalescence to Complete Recovery[3 6] ". . . we were impressed[3] with the efficacy of Nilevar as an anabolic agent. All of the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

The actions of Nilevar[4] in reversing a negative nitrogen balance—and therefore a negative protein balance—improving the appetite and increasing the sense of well-being can be expected to shorten the illness and the convalescence of these patients.

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., and Tabachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Jomison, R. M.: General Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldfarb, A. F.; Napp, E. E.; Stone, M. L.; Zuckermon, M. B., and Simon, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 4. Batson, R.: Investigator's Report, Feb. 11, 1956. 5. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Humon Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.



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BLUE SHIELD

Health Benefits For Retired Federal Employees

To the eternal credit of dedicated representatives of national Blue Cross-Blue Shield and the United States Civil Service Commission, the comprehensive health benefits program for employees of the federal government is off to a flying start with a minimum of confusion and misgivings. For the first time the federal government is providing its employees with a health benefits program more nearly in line with that in business and industry, with a portion of the cost being paid by the employer.

Unfortunately, the Health Benefits Act of 1959 failed to include former employees of the federal government who retired prior to the date on which they could have participated in the new program. It comes as no surprise that those who fall into this category have protested their exclusion and have made their dissatisfaction known to their Congressmen positively enough to have produced action. Before the original Act went into effect, legislation had already been introduced which could be pointed to a conscientious attempt to correct this inequity.

In presenting testimony on two such bills—S. 2575 and H.R. 12495—representatives of the Blue Cross Association jointly with those from the National Association of Blue Shield Plans reiterated their traditional position that adequate health care coverage must be provided for persons of retirement age. Neither of the two bills meets these requirements. Each attempts to solve the problem by isolating these older persons into a group to themselves, pointing up vividly the unsoundness of providing separate coverage for the aged. Rates for protection against the costs of illness can be kept within reason only if a sufficient number of the younger and healthier are included to balanced heavier utilization by older persons. These retired persons constitute a group which will be constantly increasing in average age. Under the proposed legislation there would be no possibility of introducing new and younger people into the group, with the ultimate result that there would have to be an ever increasing cost to each person in the group.

The necessity to have new laws to correct this omission must be questioned since it appears that a simple amendment to the existing Act would solve the problem. That is, it could if Congressmen wish to avoid further charges of discrimination by providing no less coverage for former retirees than those who will retire in years to come. Regardless of how it is accomplished—by new laws or by amendments—it is obvious that these people can get better benefits at more reasonable costs if permitted to remain in or become a part of existing, continuing plans, than if they are isolated in a continuously diminishing group.

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

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specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis In Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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OTHERS ARE SAYING

"You Are Old, Father William. . . ."

Not so long ago, it seems, old people were just old people, gentle, withering relics of the past typified by Whistler's portrait of his mother. True, they had their problems then, but who hadn't? Some were incapacitated, others spry; some were broke, others solvent; some were happy, some sad.

Now our modern old people, more numerous than before thanks to modern doctors, modern medical science, and modern private enterprise in medicine, have been metamorphosed. From being just old people they have become recently desirable, valuable political assets! Each has a genuine, exercisable franchise; some 15,000,000 potentially purchasable ballots! Purchasable by inducement —not in cash but by "benefits."

Both major political parties are offering bids, the Democrats a Forand-type bill, the Republicans a Javits-type bill. Suddenly the health of the aged becomes the grave concern of others besides the doctors.

Assuredly the old folks have not offered their votes for sale; the most many ask for is the privilege of continuing to work gainfully after sixty-five, not for a pittance but according to their ability to earn and to pay their taxes, employ their own doctors, and buy their own insurance.

In all the election year turmoil over the health of the old who hears any concern expressed over the employers, the business men, the small and large shop operators, and others, men who create employment for the young? In this election year and every year, many thousands of young people will for the first time have fastened about their necks the yoke of withholding taxes, Social Security taxes, rent, state, local taxes, union dues, and the national debt. The young—don't they enjoy the prospect of some forty-seven years of work-filled and tax-ridden pursuit of happiness?

The young people—will they not find it increasingly difficult in this inflation-ridden election year and those to follow to buy bread for themselves and their children? Who cares? Let them eat cake! They are only the young. Will they find in their midst anyone to arise and say in a loud voice to politicians of both parties; Thou shalt

(Continued on page 308)



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

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wherever there is inflammation, swelling, pain

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Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

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Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.
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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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rapidly spreading rhus dermatitis healed within a week[1]





INFECTED LACERATION

marked reversal in 3 days . . . returned to school . . . closure advanced[1]





THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS

normal routine resumed after 4 days of VARIDASE[1]



(Continued from page 304)

not press down upon the brow of youth a crown of aging thorns!

New York State Journal of Medicine
May 15, 1960

STATE NEWS ITEMS

The fall meeting of the Florida Radiological Society will be held on October 15 and 16 at the Galt Ocean Mile Hotel in Fort Lauderdale. The scientific session is scheduled from 9:00 to 12:00 and from 1:30 to 5:00 in the Compass Room on the opening day and will be followed by a cocktail party and dinner. The business meeting takes place the following day from 9:00 to 12:00 o'clock.

Dr. John P. Stewart of Fort Myers is president; Dr. John P. Ferrell of St. Petersburg, president-elect; Dr. Ivan Isaacs of Jacksonville, vice president; Dr. Alfred G. Levin of Miami, secretary, and Dr. Richard D. Shapiro of Miami Beach, treasurer.

Dr. Jere W. Annis of Lakeland has been appointed a member of the Economic Security Committee of the Chamber of Commerce of the United States.

Dr. Francis W. Glenn of Coral Gables was the guest of Dr. John Royal Moore, president of the American Orthopaedic Association, at its annual meeting held the last of May and the first part of June at the Homestead, Hot Springs, Va.

Dr. Harold L. Sanders of Tampa attended the recent meeting of the James Ewing Society held in New York City and the meeting of the Society of Head and Neck Surgeons at Philadelphia. Dr. Sanders has been elected to membership in the latter group.

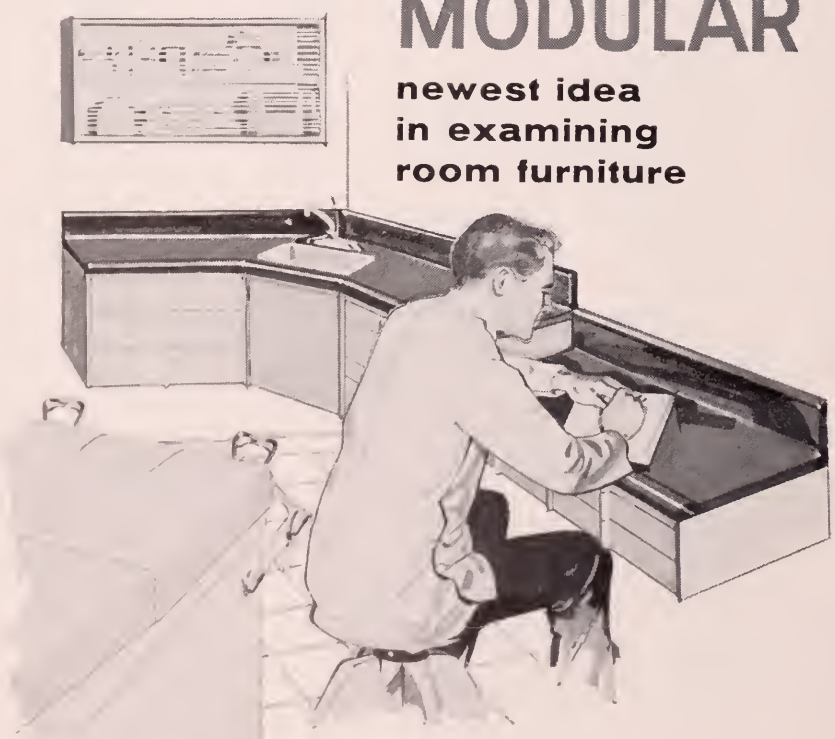
Dr. John A. Mease Jr. of Dunedin reported on the recent postgraduate Seminar on Arthritis held at Miami during a July grand staff meeting of the Mease Hospital and Clinic at Dunedin.

Dr. Edward A. Talmage of Miami presented a paper entitled "The Paradox of Narcotics and Relaxants in Pulmonary Ventilation Under Anesthesia" at the annual scientific session of the

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Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly –often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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Guthrie Clinic Alumni Association held the latter part of June in Sayre, Pa.

Dr. Warren W. Quillian of Coral Gables presented two papers at the Southern Obstetric and Gynecologic Seminar held July 28-August 3 at Asheville, N. C. and also served as moderator for an afternoon conference. The opening day of the Seminar Dr. Quillian presented "Interrelationship of the Pediatrician and Obstetrician" and the following day, he spoke on the topic "Emergencies of the Newborn."

The University of Miami School of Medicine will sponsor an all day symposium on "Medical Aspects of Marriage and the Family" at the Dupont Plaza Hotel, Miami, on Sunday, November 13. Registration is open to physicians only and there is no charge for the sessions or meal functions.

The Medical-Health Section of the United States Civil Defense Council will meet September 21-22 in the Leamington Hotel at Minneapolis, Minn. Dr. William C. Ballard of St. Petersburg is a member of the Medical-Health Committee.

Drs. M. Eugene Flipse and George M. Erickson of Miami, and Dr. Franklin J. Evans of Coral Gables will discuss "The Status of Live Virus Polio Vaccine" at the annual convention of the Florida Public Health Association being held October 13-15 at Miami Beach. Dr. Clarence M. Sharp of Jacksonville is program chairman and Dr. James O. Bond also of Jacksonville is co-chairman.

Thomas Moore Jr., a student at the University of Florida College of Medicine, has been taking his basic clerkship in psychiatry at Anclote Manor at Tarpon Springs. Mr. Moore has been at the institution all summer as a portion of the curriculum in the third year of training at the College of Medicine.

The Duke University Medical School is sponsoring a postgraduate Medical Seminar Cruise to the West Indies this fall aboard the new "Kungsholm," Sweden's largest transatlantic liner and cruise ship. The luxury ship, which will sail from New York on November 9, will visit the Virgin Islands and San Juan, and will return to New York on November 18. Information may be ob-

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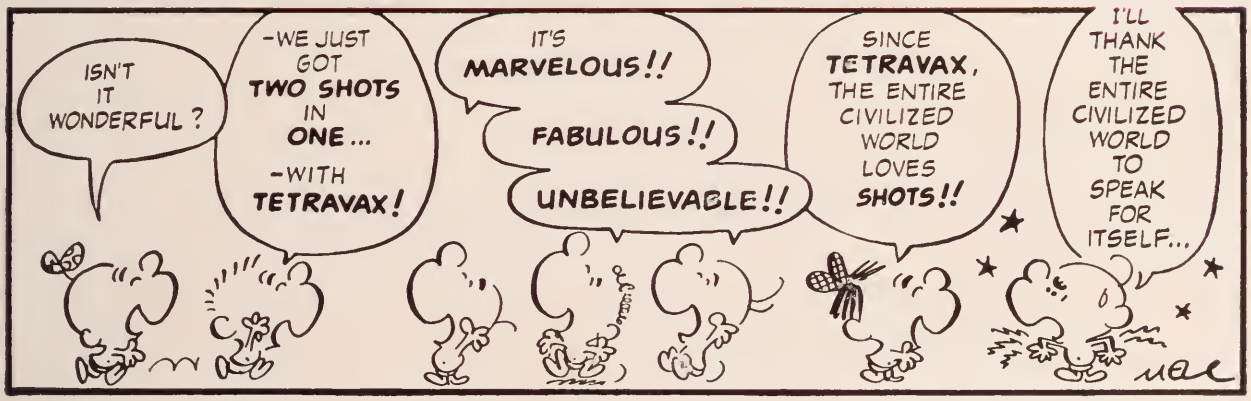
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tained from Dr. W. M. Nicholson, Assistant Dean for Post Graduate Medical Education, Duke University Medical Center, Durham, N. C.

Dr. William C. Thomas Jr. of Gainesville, Assistant Professor of Medicine at the University of Florida College of Medicine, returned to the United States July 24 after having been in Copenhagen, Denmark, where he presented a paper entitled "Studies on Mechanism of Formation of Renal Stones" at the International Congress of Endocrinology.

Dr. George W. Karelas of Newberry discussed "Medical Aspect of Aging" as a part of the program of the Health and Safety Workshop held at the University of Florida the week of July 18-22.

Dr. M. Jay Flipse of Miami has begun serving as president of the American College of Chest Physicians following his installation at the 26th annual meeting of the College held at Miami Beach.

Dr. Ralph W. Jack of Miami, Immediate Past President of the Florida Medical Association, served as a delegate from Florida to the Republican National Convention held in Chicago the latter part of July.

Dr. J. Champneys Taylor of Jacksonville participated in the program of the Southern Obstetric and Gynecologic Seminar held at Asheville, N. C., July 28-August 3. Dr. Taylor presented two papers; one "Artificial Insemination" on Saturday, July 30, and the other "Love and Marriage" on Tuesday, August 2. Later that day he also served as a member of a conference committee.

Dr. William H. Everts of West Palm Beach, chairman of the legal committee of the Palm Beach County Medical Society, was principal speaker at the regular meeting of the Palm Beach County Bar Association the middle of July.

Dr. Willett E. Wentzel of Bradenton, president of the Manatee County Medical Society, addressed the members of the Manatee County Health Council at their regular meeting early in July.

NEW Design . . . Appearance . . . Versatility

Burdick EK-III Dual-Speed Electrocardiograph



The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

Special Features:
Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design.
Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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REFER TO PDR Page 753

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extra-dietary vitamin B_{12},

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WANTED: Radiologist seeking associate—congenial Orlando area. Limited volume, currently diagnosis only. Some hospital work. Florida license required. Write 69-322, P.O. Box 2411, Jacksonville, Fla.

WANTED: Two young associates for General Practice. One with training in anesthesia, the other in surgery, to be associated with General Practitioner with 28 bed hospital. Florida license required. Will guarantee suitable associates $1000 per month with partnership later. Write 69-352, P. O. Box 2411, Jacksonville, Fla.

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PHYSICIAN WANTED: Rare opportunity in fast growing town of 11,000 needing one or two doctors. Excellent 75 bed, modern hospital. Well equipped office of recently deceased doctor including X-Ray, Laboratory, EKG, etc. County has population of 51,000 with only nine doctors. Adjoining county has no doctor. Financial assistance available. Write 69-385, P. O. Box 2411, Jacksonville, Fla.

MEDICAL SUITE AVAILABLE. July 1 in St. Nicholas Medical Center, 3127 Atlantic Blvd., Jacksonville. Completely balanced occupancy for medical and dental professions. All utilities furnished including background music. Air-conditioned. Off street parking. Can be leased for $190.00 per mo. Call or write Mr. W. G. Allen Jr., 3102 Atlantic Blvd., Jacksonville. EX 8-5500.

WANTED: General Practitioner and Pediatrician for group practice with present doctors. Unusual opportunity in the fastest growing area of West Coast Florida midway on a main street between St. Petersburg and Clearwater. Inquire: Midway Medical Center, 10700 Seminole Blvd., Largo, Fla., Phone Juniper 4-7215.

ANESTHESIOLOGY FELLOWSHIP AVAILABLE: Fully approved two year program clinical experience 350 bed teaching hospital. Basic science program integrated with Dr. John Adriani's anesthesiology program at Charity Hospital. Applicant must be licenseable in Louisiana. For information write Dr. F. X. Letard, Director of Residency training program anesthesiology, Ochsner Foundation Hospital, New Orleans, Louisiana.

WANTED: Internist, board qualified or board certified, to be associated with two Internists in group. Minimum guaranteed salary of $12,000, plus percentage for the first year, with eventual full partnership. Office located on east coast between Palm Beach and Miami. Write 69-379, P. O. Box 2411, Jacksonville, Fla.

FOR SALE: Well established medical practice, including furnishings and equipment—Coral Gables location. Write 69-351, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Established medical practice with new, single occupancy medical building. Ample off-street parking. Fully equipped for General Practice or Internal Medicine. Includes central air conditioning and heating, BMR, EKG, X-ray and complete equipment, almost new. In fastest growing section of Greater Jacksonville. Retiring and will work reasonable period with new doctor. Fair valuation and terms. Respond to Box 999, P. O. Box 5604, Jacksonville 7, Fla.

MEDICAL BUILDING—FORT LAUDERDALE—newly completed—successful—72% rented. Located on one of Fort Lauderdale's major traffic arteries. Has definite need for General Practitioner, Internist, Surgeon, Dermatologist. For information and literature, call or write RoMark Bldg., 3521 W. Broward Blvd. Reverse charges accepted. Phone LU 1-0900.

FOR SALE: 200 M.A. Keleket X-Ray with wall cassette, screen, goggles, lead gloves and apron; 15 M.A. Picker X-Ray; Zimmer Bone set; property of an estate. Write Potter, Langbein, Burdick and Silvian, 205 Datura Street, W. Palm Beach, for information.

FOR RENT: Air conditioned office in Professional building. Off-street parking adjacent to bank, main post office, department stores and central plaza shopping center, the largest in St. Petersburg. Contact Ben C. Roe, 21-30th St., S., St. Petersburg, Fla.

G. U. RESIDENCY: recently approved, three year program in large charity and private hospital. Large outpatient load. Second year at local V. A. Hospital. Full complement of interns and seven other residency programs. American graduates only. Director, Medical Education, Tampa General Hospital, Tampa, Fla.

WANTED: Resident for coverage of Emergency Room in 200 bed general hospital. Graduate of approved medical school. Contact Holy Cross Hospital, Fort Lauderdale, Fla.

WANTED: Ritter surgical table in good condition. Also office autoclave. Please quote prices. Contact P. O. Box 1211, Clearwater, Fla.

DOCTORS OFFICE: Available soon. Ground floor, living quarters upstairs if desired. Building formerly used as hospital. Present occupant building own office. Only one doctor in south half of county. Splendid opening. Contact Miss Aurie Lee Beville, Bushnell, Fla.

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LOCATE IN NEW MEDICAL CENTER: Opening for GP, Urologist, Pediatrician, Obstetrician in new home development of 14,000 and growing. Now without doctors. Financing available. Contact Soutel Pharmacy, 4940 Soutel Dr., Jacksonville, Fla.

WANTED: Rapidly expanding group seeking Internist, Ophthalmologist, Otolaryngologist, Obstetrician-Gynecologist, and General Practitioner. Modern Clinic building and Fully Accredited hospital located on Florida west coast. Specialty Board certification or Eligibility and Florida license required. Write 69-388, P. O. Box 2411, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Bate, Doris F., Miami Beach.

Culberson, Jerry D., St. Petersburg

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Lease your equipment and save your cash!

Check with your Medical Supply representative on the new way to outfit your office or modernize your facilities. It's simple—just have the equipment you need delivered and pay a monthly rental fee. Let us show you how to save money and have the finest facilities at the same time. . . . You will be amazed!

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Moore, Gene, Wauchula
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Howarth, Mary S., DeLand
Pellicane, Anthony, J. Jr., S. Miami
Ross, I. Randall, Miami
Shaw, E. Russell, S. Miami
Smouse, William R., Fort Lauderdale

OBITUARIES

Jerome Mayer Greenhouse

Dr. Jerome Mayer Greenhouse of Hollywood died on April 4, 1960 of coronary thrombosis. He was 44 years of age.

The son of Joseph and Birdie Greenhouse, Dr. Greenhouse was born in St. Louis, Mo., on Oct. 15, 1915. He received his elementary, academic and medical training in his native city. After completion of his public school education, he attended St. Louis University and upon graduation continued his professional studies there. He was awarded the degree of Doctor of Medicine by St. Louis University School of Medicine in 1939. He interned at St. Louis City Hospital and later served residencies at the Alexian Brothers Hospital and the Barnes Hospital. He then joined the staff of the Barnard Free Skin and Cancer Hospital, where he became the student and friend of the illustrious Zola Cooper.

In 1955 Dr. Greenhouse located in Hollywood and immediately made an excellent reputation as

(Continued on page 356)

Reliable
PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE
with proficient defense
that cuts the cost
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899
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Now —All cold symptoms can be controlled



Tussagesic

timed-release *tablets*

Controls congestion
with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever
with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

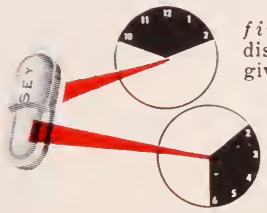
TRIAMINIC® .....50 mg.
(phenylpropanolamine HCl .....25 mg.
pheniramine maleate .....12.5 mg.
pyrilamine maleate .....12.5 mg.)
Dormethan
(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate .....180 mg.
APAP (N-acetyl-p-aminophenol) .....325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

Controls cough centrally
with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus
with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

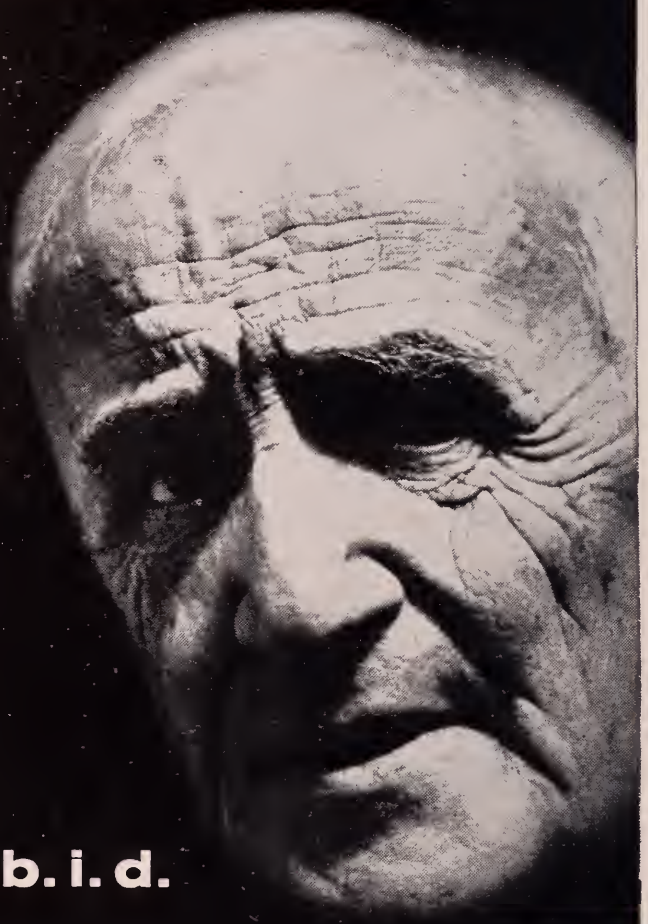
then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

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IN SENILE CONFUSION . . .



CONTINUOUS CEREBRAL OXYGENATION

WITH

ONE

Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio

Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

[redacted]

in premenstrual tension only neo Bromth treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee

now–for more comprehensive control of *'pain & spasm'*



INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to
or associated with
-spasm of skeletal muscle

a new muscle relaxant-analgesic



Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects . . . . . 400 mg.

  *Methocarbamol Robins U.S. Pat. No. 2770649

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent. . . . (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Additional information available upon request.

Robins

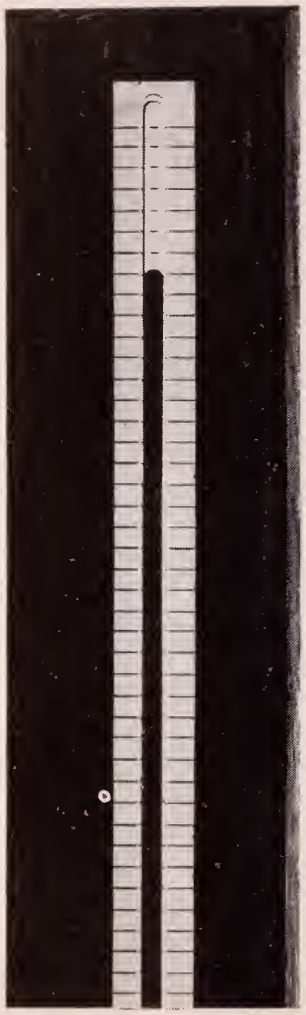
A. H. ROBINS CO., INC., Richmond 20, Virginia

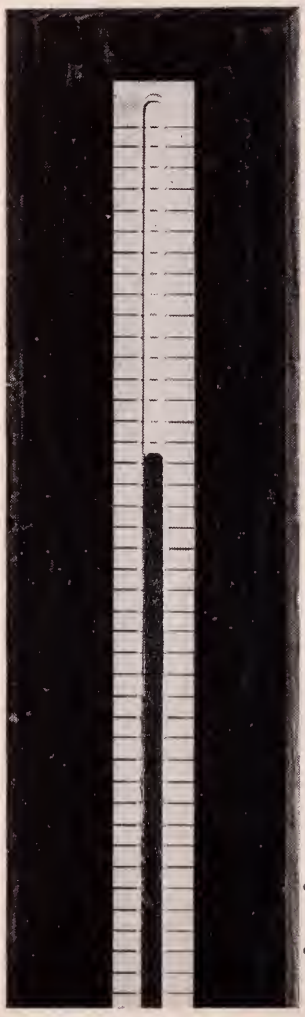
Making today's medicines with integrity . . . seeking tomorrow's with persistence

for a smooth downward curve

New Rautrax-N results in prompt lowering of blood pressure.[1] Rautrax-N, a new and carefully developed antihypertensive-diuretic preparation, provides improved therapeutic action[1] plus enhanced diuretic safety for all degrees of essential hypertension. A combination of Raudixin and Naturetin, Rautrax-N facilitates the management of hypertension when rauwolfia alone proves inadequate, or when prolonged treatment, with or without associated edema, is indicated.

Naturetin, the diuretic of choice, also possesses marked antihypertensive properties, thus complementing the known antihypertensive action of Raudixin. In this way a lower dose of each component in Rautrax-N controls hypertension effectively with few side effects and greater margin of safety.[1-16]





Other advantages are a balanced electrolyte pattern[1-16] and the maintenance of a favorable urinary sodium-potassium excretion ratio.[2-16] Clinical studies[1-5] have shown that the diuretic component of Rautrax-N—Naturetin—has only a slight effect on serum potassium. The supplemental potassium chloride provides additional protection against potassium depletion which may occur during long term therapy.

Rautrax-N may be used alone or in conjunction with other antihypertensive drugs, such as ganglionic blocking agents, veratrum or hydralazine, when such regimens are needed in the occasionally difficult patient.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin (Squibb Rauwolfia Serpentina Whole Root) and 4 mg. Naturetin (Squibb Benzydroflumethiazide), with 400 mg. potassium chloride.

Dosage: Initially-1 to 4 tablets daily after meals. Maintenance-1 or 2 tablets daily after meals; maintenance dosage may range from 1 to 4 tablets daily. For complete instructions and precautions see package insert. Literature available on request.

References: 1. Reports to the Squibb Institute, 1960. 2. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 3. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 4. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. 5:55 (Feb.) 1960. 5. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 6. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 7. Cohen, B. M.: M. Times, to be published. 8. Breneman, G. M. and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 9. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 10. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 11. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 12. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 13. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 14. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 15. Kahn, A., and Grenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 16. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

Squibb Quality—the Priceless Ingredient

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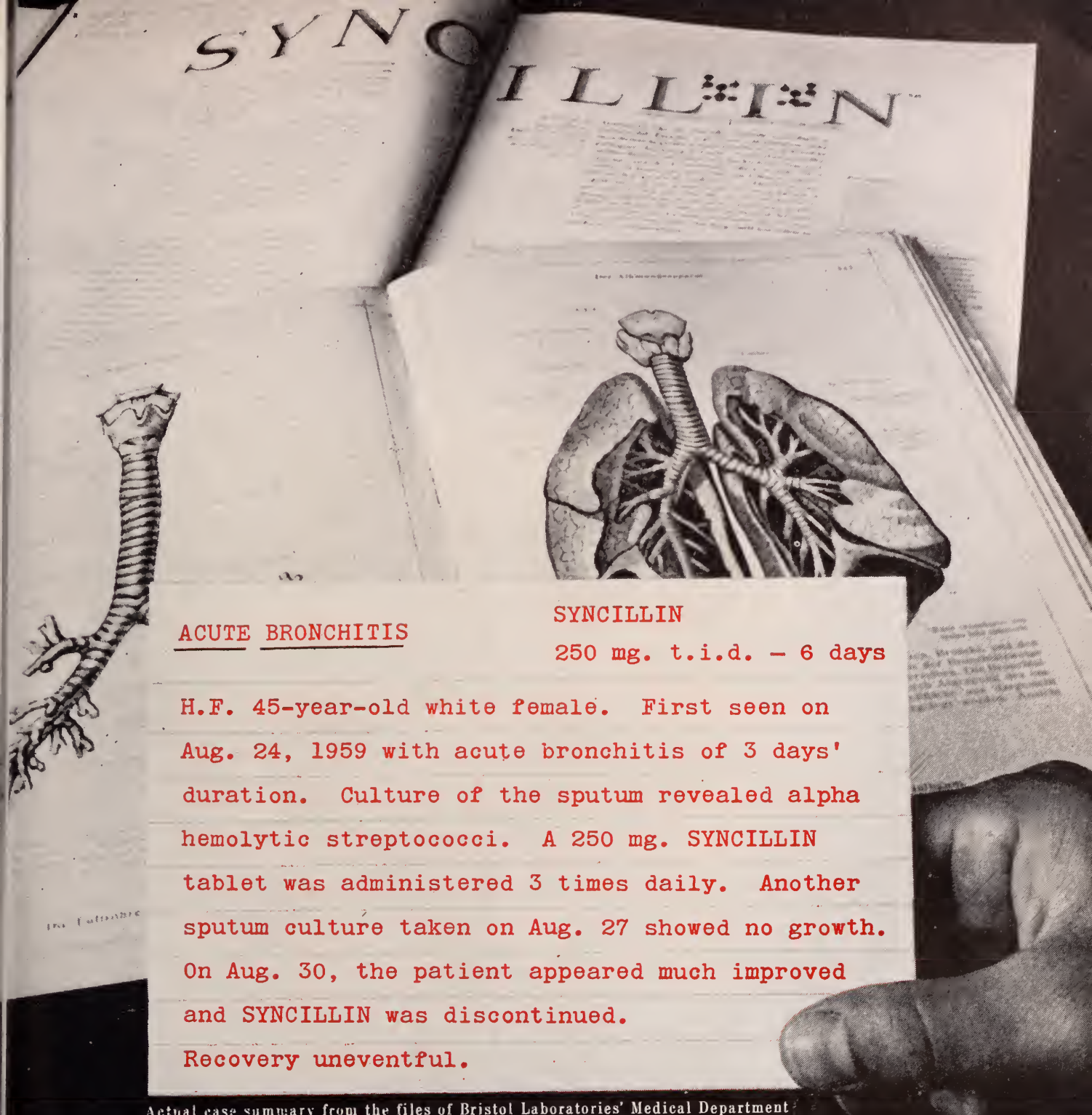
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The proved, effective antihypertensive—now combined with a safer, better diuretic

RAUTRAX-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride



ACUTE BRONCHITIS

SYNCILLIN
250 mg. t.i.d. – 6 days

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued. Recovery uneventful.

Actual case summary from the files of Bristol Laboratories' Medical Department

THE ORIGINAL potassium phenethicillin

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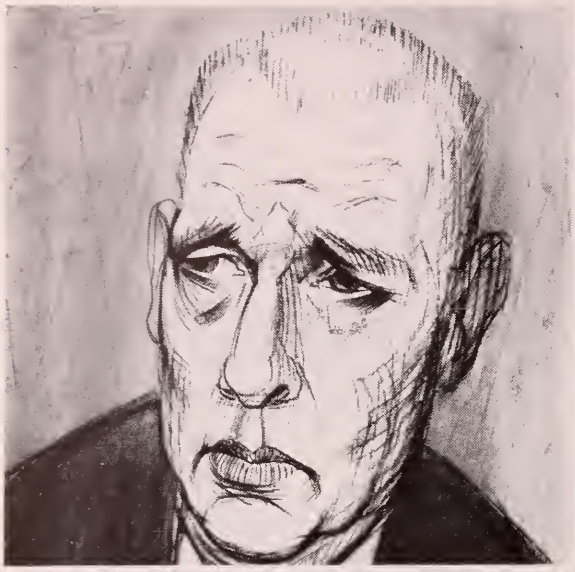
(Potassium Penicillin-152)

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

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whenever depression complicates the picture

Tofrānil®
brand of imipramine HCl



hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

Geigy, Ardsley, New York

160-60

CONSISTENTLY GOOD CLINICAL RESULTS IN TRICHOMONAL AND MONILIAL VAGINITIS

TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®

IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. SUPPOSITORIES for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.
Also available:
box of 12 suppositories with applicator.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK



even in allergic infants



FROM A CLINICAL STUDY* IN ANNALS OF ALLERGY

Patients	200 infants and children, ages 2 months to 14 years
Diagnosis	Perennial allergic rhinitis
Therapy	Dimetane Elixir
Results	in 149, *good* results / in 40, *fair* results
Side Effects	Encountered in *only* 7 patients (in all except one, the side effect was mild drowsiness)

In allergic patients *of all ages,* Dimetane has been shown to work with an effectiveness rate of about 90% and to produce an exceptionally low incidence of side effects. Complete clinical data are available on request to the Medical Department. *Supplied:* DIMETANE Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new DIMETANE-100 Injectable (100 mg./cc.).

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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

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no irritating crystals[1] · uniform concentration in each drop[2]

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1. Lippmann, O.: Arch. Ophth. 57:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. 46:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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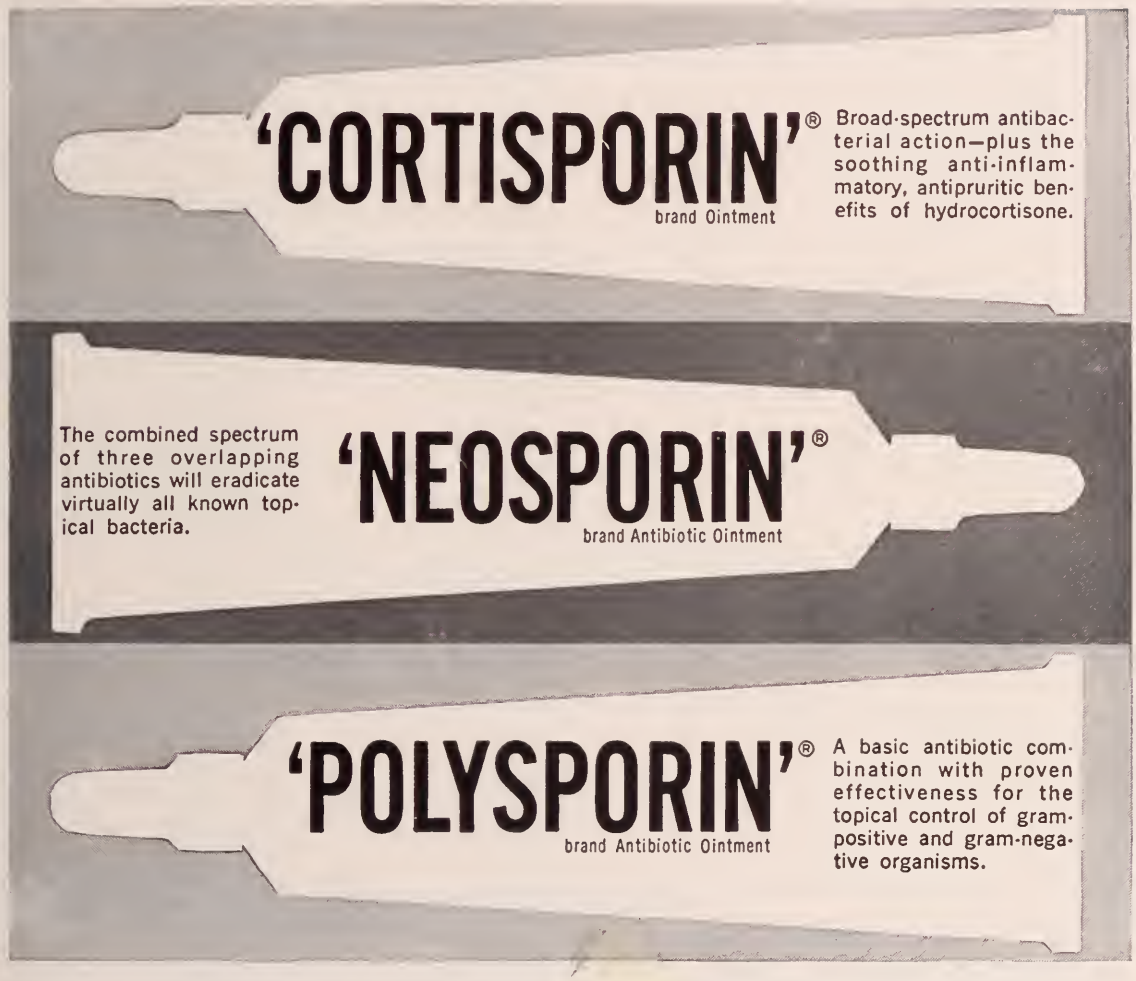
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Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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ALMOST INVARIABLY COOL DOWN

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20 Atopic dermatitis	8	10	2
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SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

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1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

**patent pending*
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a new, improved, more potent relaxant for anxiety and tension

- effective in half the dosage required with meprobamate
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- a familiar spectrum of antianxiety and muscle-relaxant activity
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STRIATRAN is indicated in anxiety and tension, occurring alone or in association with a variety of clinical conditions.

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Supply: 200 mg. tablets, coated pink, bottles of 100.

While no absolute contraindications have been found for Striatran in full recommended dosage, the usual precautions and observations for new drugs are advised.

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unequalled in palatability

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MRT *M. R. Thompson, Inc.* CRANFORD, N. J.

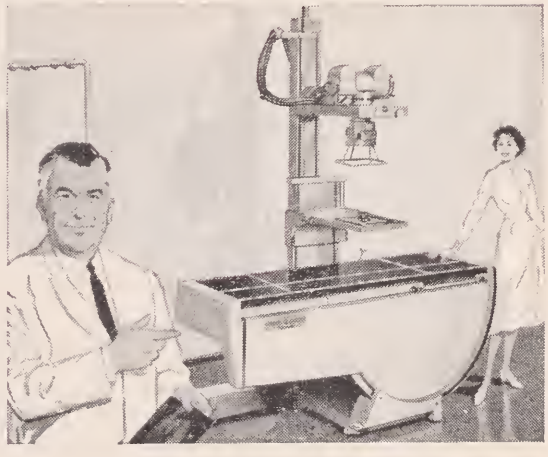
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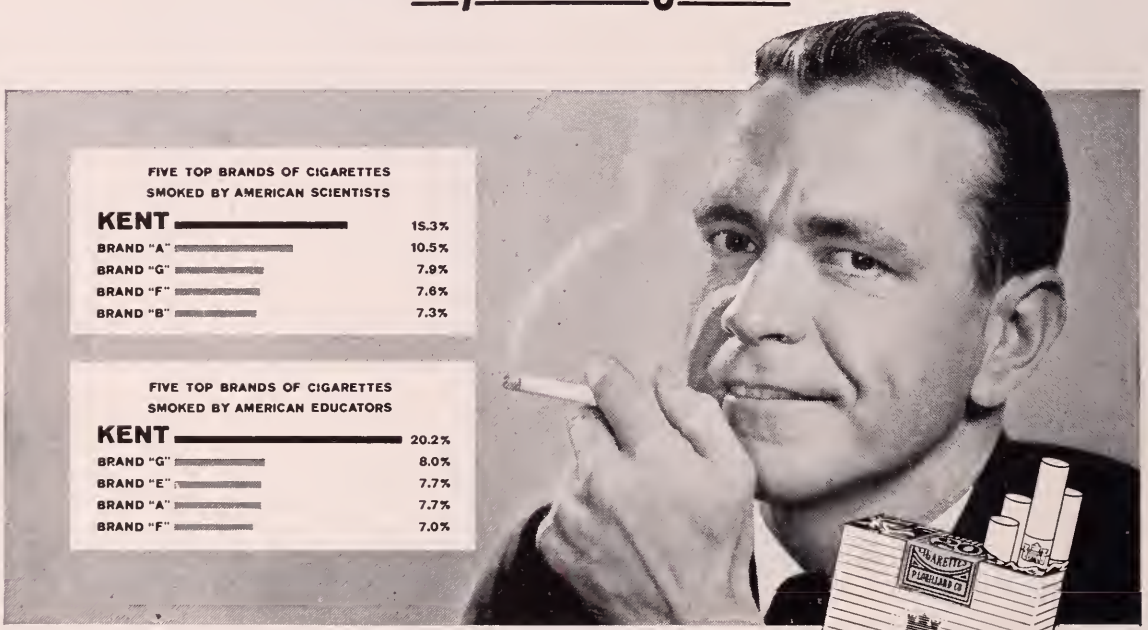
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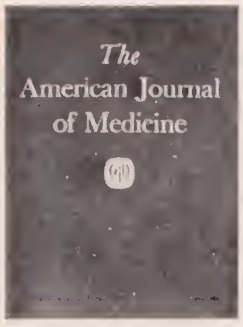
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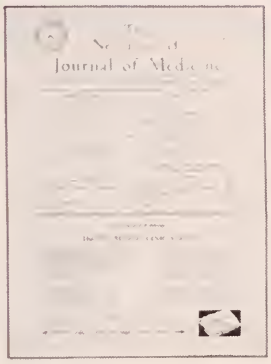
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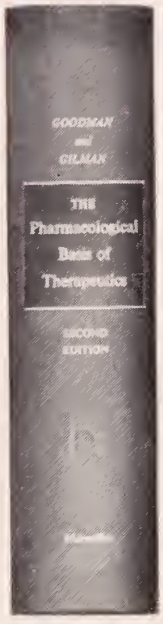
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Individually, folic acid and B_{12} fill important clinical roles.[1] But, increasing evidence indicates that multivitamins containing folic acid may obscure the diagnosis of pernicious anemia.[2-7] And vitamin B_{12}, in indiscriminate and unnecessary usage[5-8] is likewise blamed for this diagnostic confusion.[7]

Both folic acid and B_{12} have been omitted from Adabee, in recognition of this growing medical concern. Also excluded are other factors which might interfere with concurrent therapy, such as, hormones, enzymes, amino acids, and yeast derivatives. Adabee supplies massive doses of therapeutically practical vitamins for use in both specific and supportive schedules in illness and stress situations. Thus, new Adabee offers the therapeutic advantage of sustained maximum multivitamin support without the threat of symptom-masking.

references: 1. Wintrobe, M. M., *Clinical Hematology*, 3rd ed., Phila., Lea & Febiger, 1952, p. 398. 2. Goodman, L. S. and Gilman, A., *The Pharmacological Basis of Therapeutics*, 2nd. ed., New York, Macmillan, 1955, p. 1709. 3. New Eng. J.M., Vol. 259, No. 25, Dec. 18, 1958, p. 1231. 4. Frohlich, E. D., New Eng. J.M., 259:1221, 1958. 5. J.A.M.A., 169:41, 1959. 6. J.A.M.A., 173:240, 1960. 7. Goldsmith, G. A., American J. of M., 25:680, 1958. 8. Darby, W. J., American J. of M., 25:726, 1958.

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Each yellow, capsule-shaped tablet contains:

Vitamin A	25,000 USP units
Vitamin D	1,000 USP units
Thiamine mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
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Nicotinamide (niacinamide)	50 mg.
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Ascorbic acid (vitamin C)	250 mg.

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Each green, capsule-shaped tablet contains Adabee plus nine essential minerals:

Iron	15.0 mg.	Zinc	1.5 mg.
Iodine	0.15 mg.	Potassium	5.0 mg.
Copper	1.0 mg.	Calcium	103.0 mg.
Manganese	1.0 mg.	Phosphorus	80.0 mg.
Magnesium	6.0 mg.		

indications: As dietary supplements for the deficiency states that accompany pregnancy and lactation, surgery, burns, trauma, alcohol ingestion, hyperthyroidism, infections, cardiac disease, polyuria, anorexia, cirrhosis, arthritis, colitis, diabetes mellitus, and degenerative diseases. Also in restricted diets, particularly peptic ulcer, in geriatrics, and in concurrent administration with diuretics and antibiotics.

dosage: One or more tablets a day, as indicated, preferably with meals.

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4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
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Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROLABS*—400 mg. *unmarked*, coated tablets; and as MEPROSPAN®—400 mg. and 200 mg. *continuous release* capsules.

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of clinical use...



...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

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"Gratifying" relief from

for your patients with
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POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

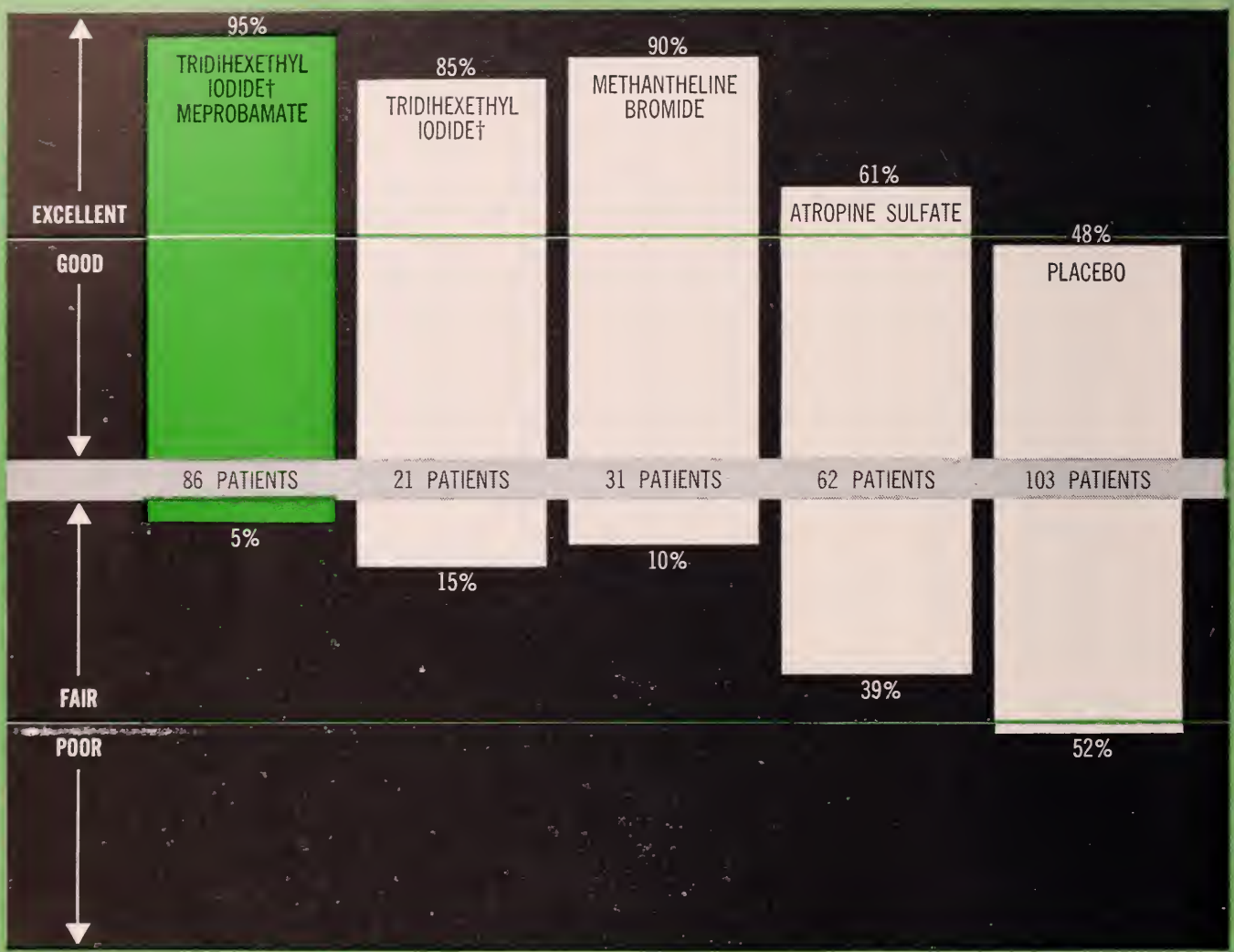
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(CARISOPRODOL, WALLACE)

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clinically proven efficacy.

in relieving tension . . . curbing hypermotility and excessive secretion in G. I. disorders



PATHIBAMATE combines two highly effective and well-toierated therapeutic agents:

Meprobamate—widely accepted tranquilizer

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PATHILON tridihexethyl chloride—anticholinergic noted for its effect on motility and gastrointestinal secretion with few unwanted side effects.

Contraindications: glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Two available dosage strengths permit adjusting therapy to the G.I. disorder and degree of associated tension.

Where a minimal meprobamate effect is preferred . . .
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Where a full meprobamate effect is preferred . . .
PATHIBAMATE-400 Tablets: 400 mg. of meprobamate; 25 mg. of PATHILON

Dosage: Average oral adult dose is 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

clinically proven safety

The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

Pictured are the results obtained with the PATHILON (tridihexethyl iodide)–meprobamate combination† in a double-blind study of 303 ulcer patients, extending over a period of 36 months.* They clearly demonstrate the efficacy of **PATHIBAMATE** in controlling the symptoms.

SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

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control the tension — treat the trauma



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

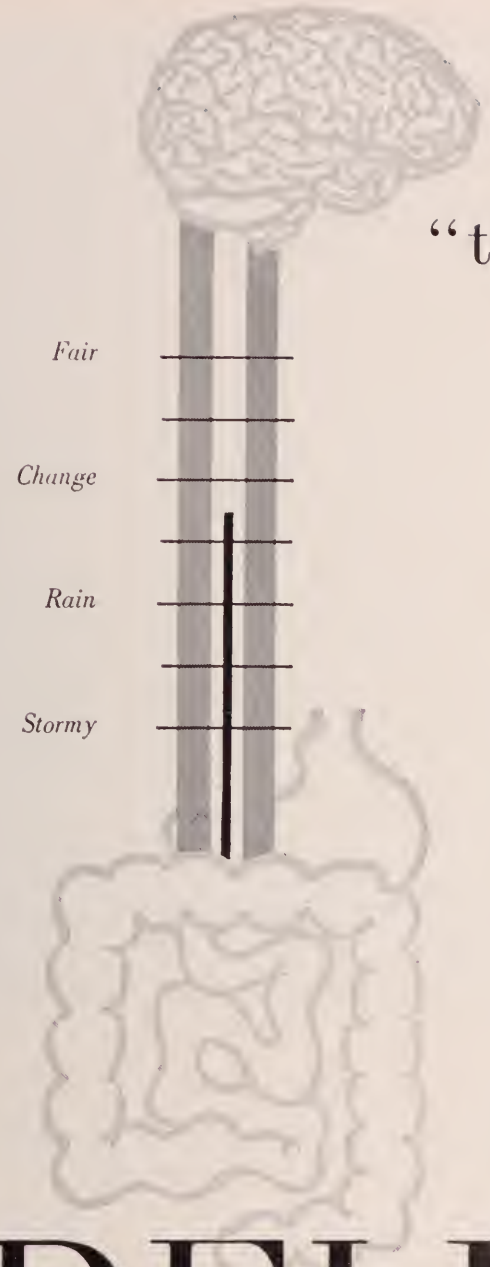
If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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"the G-I tract
is the
barometer
of the mind..."

Belbarb
soothes the agitated mind
and calms the G-I spasm
through the central effect
of phenobarbital and the
synergistic action of
fixed proportions
of natural belladonna
alkaloids on the
gastrointestinal tract.

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SEDATIVE ANTISPASMODIC

20 years of clinical satisfaction

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WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



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Lanesta® Gel

Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

A product of Lanteen® research.

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ATARAX ENCOMPASSES MORE PATIENT NEEDS...LETS YOU CHART A SAFER, MORE EFFECTIVE COURSE TO TRANQUILITY

ATARAX has a wide range of flexibility . . . from mild adult tensions and anxieties to full-blown alcoholic episodes . . . from the behavior disorders of childhood to the emotional problems of old age. Why? Because it gives you maximum adaptability of dosage . . . works quickly and predictably . . . is unsurpassed in safety.

ATARAX offers extra pharmacologic actions especially useful in certain troublesome conditions. It is antihistaminic and mildly antiarrhythmic, does not stimulate gastric secretions. Hence it is well suited to the needs of your allergic, cardiac and ulcer patients.

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Dosage: Adults, one 25 mg. tablet, or one tbsp. Syrup q.i.d. Children, 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

ATARAX®

(BRAND OF HYDROXYZINE)

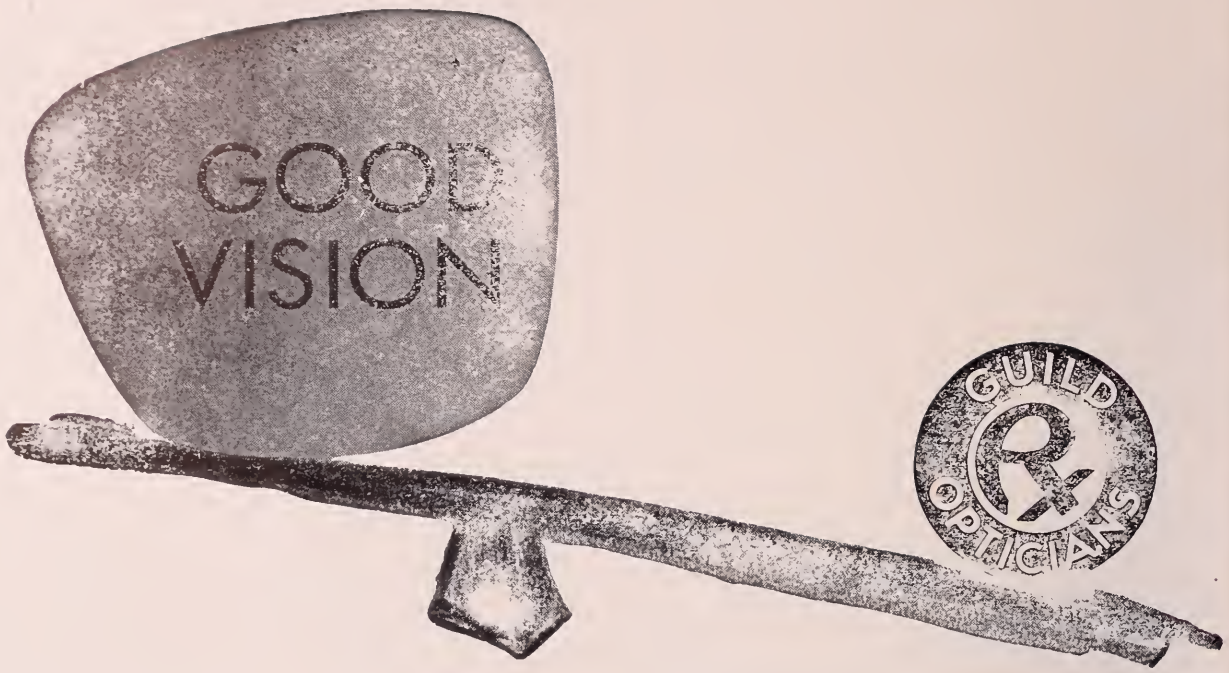
PASSPORT TO TRANQUILITY



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Today all around us cut-rate and discount houses flourish. You can buy glasses from $7.98 up. GOOD VISION comes a shade higher. In fact you can't put a price on vision. Your GUILD OPTICIAN endeavors to place the finest in eye wear before the public at the lowest possible prices.

Guild of Prescription Opticians of Florida


Trancopal®
brand of chlormezanone
effective oral skeletal
muscle relaxant
and tranquilizer
LETS THE PATIENT WALK
"HEADS UP"
in spite of torticollis.



Trancopal

relieves pain and spasm associated with torticollis.

In a recent study by Ganz, Trancopal brought considerable improvement or very effective relief to 20 of 29 patients with torticollis.[1] "The patients helped by the drug," states Ganz, "were able to carry the head in the normal position without pain." Similarly, Kearney found that in 8 of 13 patients with chronic torticollis treated with Trancopal improvement was excellent to good. ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[2]

Lichtman, in a study of patients with various musculoskeletal conditions, noted that 64 of 70 patients with torticollis obtained excellent to good relief with Trancopal.[3]

In a comparative study of four central nervous system relaxants, Lichtman reports that 26 of 40 patients found Trancopal to be the most effective drug.[3]

1. Ganz, S. E.: *J. Indiana* 52:1134, July, 1959. 2. Kearney, *Current Therap. Res.* 2:127, 1960. 3. Lichtman, A. L.: *Acad. Gen. Pract. J.* 4:28, Oct

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off. 4716

Clinical results with Trancopal®

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.



Just one prescription for **Engran** Term-Pak *(270 tablets)*
SQUIBB VITAMIN-MINERAL SUPPLEMENT
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak.

Engran is also available in bottles of 100 tablets.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'ENGRAN' AND 'TERM-PAK' ARE SQUIBB TRADEMARKS

in arthritis and allied disorders

Butazolidin®
brand of phenylbutazone
Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.

Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York





Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.



1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

* In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support VITERRA® Vitamins and Minerals
Formulated from Pfizer's line of fine pharmaceutical products.

ROERIG Rx

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™



Cartoon idea by pharmacist Emil Magdalener

Many of you may have seen a recent cartoon depicting a midnight scene in front of a pharmacy. A woman is pounding on the door and the pharmacist is leaning out the window of his apartment over the store. "Open up," shouts the woman. "My husband is sick and I need a stamp so I can send this prescription to the mail order house."

The drug that always fails is the drug that isn't there

Far-fetched? Perhaps, but there are those who would have us believe that our present system of drug distribution is inefficient and costly, and should be replaced by presumably more efficient and cheaper centralized or bureaucratic methods. Disregarding the probable political philosophy behind these suggestions, consider what a marvelously intricate and efficient system of drug distribution we have in this country. • From the laboratories of the manufacturers comes a steady stream of new and better drugs for your patients. Warehoused and stocked by drug wholesalers, these products are available in over 53,000 pharmacies scattered across the length and breadth of our land. And woe to the pharmacist who hasn't been provided with yesterday's laboratory discovery for your use in treating a patient today. • The economists speak of "utility of time" and "utility of place." We simply say that you can confidently prescribe *what* you choose, *when* it is needed, *wherever* your patient may be.

This message is brought to you by the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



Garden City, N. Y.



Lincolnwood, Ill.



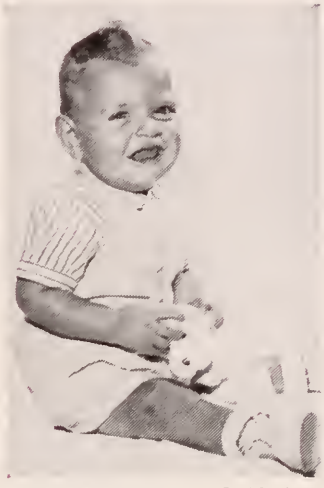
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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.
Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

SQUIBB *Squibb Quality—The Priceless Ingredient*

"DELALUTIN"® IS A SQUIBB TRADEMARK



Nutritious dishes—oysters, cottage cheese salad with peanuts and dried fruits, cole slaw, orange juice, custard—and beer

The secret of a successful high-vitamin, high-mineral diet is acceptance

The more appetizing the diet, the more likely your patient will stick to it. Dried apricots and figs with cottage cheese and peanuts attractively provides calcium, iron, vitamins A, B_2, niacin and C. Oysters, rich in iron and calcium, supply vitamins A and D.

Shredded cabbage and carrot slaw combines vitamins A and C and calcium. Oatmeal ranks high in iron and gets a generous calcium and vitamin B_6 bonus when served with molasses and milk. Custard contains calcium and vitamins A, B_1, B_2. A topping of orange juice concentrate adds vitamin C.



With your approval, beer can add zest to your patient's diet.

An 8-oz. glass of beer contains 10 mg. calcium, 50 mg. phosphorus, 1/8 min. daily requirement of niacin, smaller amounts of other B-complex vitamins. (Average of American beers)

United States Brewers Foundation

If you'd like reprints of this and 11 other different diet menus for your patients, write United States Brewers Foundation, 535 Fifth Avenue, N.Y. 17, N.Y.



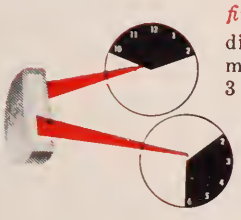
"I wouldn't be hooting all night if I were able to get my beak on some TRIAMINIC® to clear up my stuffed sinuses."

...and for humans with STUFFED-UP SINUSES...

Your patient with sinus congestion doesn't give a hoot about anything but prompt relief. And TRIAMINIC has a pharmacologically balanced formula designed to give him just that. As soon as he swallows the tablet, the medication is transported *systemically* to *all* nasal and paranasal membranes – reaching inaccessible sinus cavities where drops and sprays can never penetrate. TRIAMINIC thereby brings more complete, more effective relief without hazards of topical therapy, such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then – the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

(Continued from page 316)

clinician, teacher, lecturer and writer. He was deeply dedicated to the sciences of dermatology and dermatopathology and had instituted the foundation for a department of dermatology in Memorial Hospital just prior to his sudden death. Interests other than professional included art, music, literature, aquatic sports and the cultural improvement of his community. He was devoutly religious, glorying in the great Hebrew religious inheritance.

Dr. Greenhouse was a member of the Broward County Medical Association and of the Florida Medical Association. He also held membership in the American Medical Association and his specialty societies.

George Paul Beach

Dr. George Paul Beach of Daytona Beach died on June 12, 1960, by drowning in Ponce De Leon Inlet near that city in an attempt to save the life of his nine year old son, Gary, following capsizing of their boat. He was 49 years of age.

Dr. Beach was born on March 6, 1911, in Sandersonville, Ga. Upon graduation from the Groveland (Florida) High School, he attended St. Mary's University in San Antonio, Texas, and later the University of Texas in Austin. He also attended Emory University in Atlanta, Ga. He received his medical training at the University of Texas Medical Branch in Galveston and was awarded the degree of Doctor of Medicine by that institution in 1942. Sigma Chi was his fraternity and Alpha Kappa Kappa was his medical fraternity.

During World War II, Dr. Beach served with the 98th General Hospital in Europe, retiring as Chief of Orthopedics in 1946. He then served a residency in Orthopedics at the University of Oklahoma School of Medicine in Oklahoma City and during 1947 was a member of the faculty of the University of Tennessee College of Medicine in Memphis.

Returning to Florida, Dr. Beach was for several years associated with Dr. John F. Lovejoy in the practice of orthopedic surgery in Jacksonville. In 1951 he located in Daytona Beach and continued to practice his specialty there until he met his untimely death.

Dr. Beach was a member of the Volusia County Medical Society and since 1949 had held membership in the Florida Medical Association.



He also held membership in the American Medical Association and the Florida Orthopedic Society. He was certified by the American Board of Orthopedic Surgery and was a fellow of the American Academy of Orthopedic Surgery.

Surviving are the widow, Mrs. Eunice Beach, and three small daughters, of Daytona Beach; and a brother, Dr. Asa Beach, of San Antonio, Texas.

BOOK REVIEWS

Current Therapy—1960. *Latest Approved Methods of Treatment for the Practicing Physician.* Pp. 808. Price $12.00. Philadelphia, W. B. Saunders Company, 1960.

In this twelfth edition of this series of annual volumes on Current Therapy the purpose continues to be to bring to the physician authoritative and factual information in a form consistent with ready reference and practical application. It is not a book of recent advances only, but also is a statement of methods, regardless of date of origin, currently employed by outstanding therapeutists. The criterion is effectiveness, not necessarily newness. Today's most useful treatment measures for some 400 common disorders are concisely described by 308 contributors, each presenting the treatment he has used most successfully in his own daily practice. These measures range from alleviating the common cold to managing complications in multiple sclerosis. For each disease and disorder, specific and symptomatic treatments are considered under individual headings, and in most cases therapy is broken down into separate numbered steps. Exact dosages are given and prescriptions written out when necessary. There are 240 articles which are improved in some significant manner over last year. They are either written by a new author presenting a different viewpoint, or show latest refinements in technique, or contain completely new and better treatments from the best known last year for particular disorders. For general physician or specialist, the 1960 volume offers a full measure of swift, up-to-date help on specific therapeutic methods for management of virtually all common diseases and disorders.

The Physician and the Law. By Rowland H. Long, LLB., LLM. Ed. 2. Pp. 302. Price, $5.95. New York, Appleton-Century-Crofts, Inc., 1959.

The purpose of this book is twofold: to afford the practicing physician some knowledge of the rules of law which govern his conduct in the physician-patient relationship, and to help the physician who has to appear in court as a witness in a case in which it is necessary to prove facts relating to injury, disease, and the causal relation between injury or disease and death. In this second edition cases of importance decided since the issue of the first edition are presented and the text has been revised and brought up to date. The author states that evidence of an alarming increase in the number of malpractice claims is nationwide and that verdicts are truly shocking. He cites verdicts in California for $250,000 and $210,000, in Tennessee for $200,000, in Texas for $100,000, in Florida for $65,000, and one given by a federal jury for $123,000. Even more frightening are the inroads being made upon sound principles of law, which have shielded the medical profession from jury speculation.

(Continued on page 361)

push-button control in

skin inflammation, itching, allergy



PANTHO-FOAM

This non-occlusive foam lets the skin "breathe" as it "puts out the fire" of inflammation — unlike ordinary ointments.

Applied directly on affected area, **pantho-Foam** is today's non-traumatizing way to provide prompt relief and healing in . . .

burns
eczemas (infantile, lichenified, etc.)
dermatitis (atopic, contact, eczematoid)
neurodermatitis
pruritus ani et vulvae
stasis dermatitis

supplied: aerosol container of 2 oz.

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Q. *When you want to reduce serum cholesterol and maintain it at a low level, is medication more realistic than dietary modifications?*

A. *Maintenance of lowered cholesterol concentration in the blood is a life-long problem. It is usually preferable, therefore, to try to obtain the desired results through simple dietary modification. This spares the patient added expense and permits him meals he will relish.*

The modification is based on a diet to maintain optimum weight plus a judicious substitution of the poly-unsaturated oils for the saturated fats. One very simple part of the change is to cook the selected foods with poly-unsaturated Wesson. In the prescribed diet, this switch in type of fat will help to lower blood serum cholesterol and help maintain it at low levels. The use of Wesson permits a diet planned around many favorite and popular foods. Thus the patient finds it a pleasant, easy matter to adhere to the prescribed course.



Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson. No significant variations are permitted in the 22 exacting specifications required before bottling.

Wesson satisfies the most exacting appetites. To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Chicken, grilled with homemade Wesson barbecue sauce, is low in saturated fat—and delicious eating. It gives longer lasting satisfaction.



FREE *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

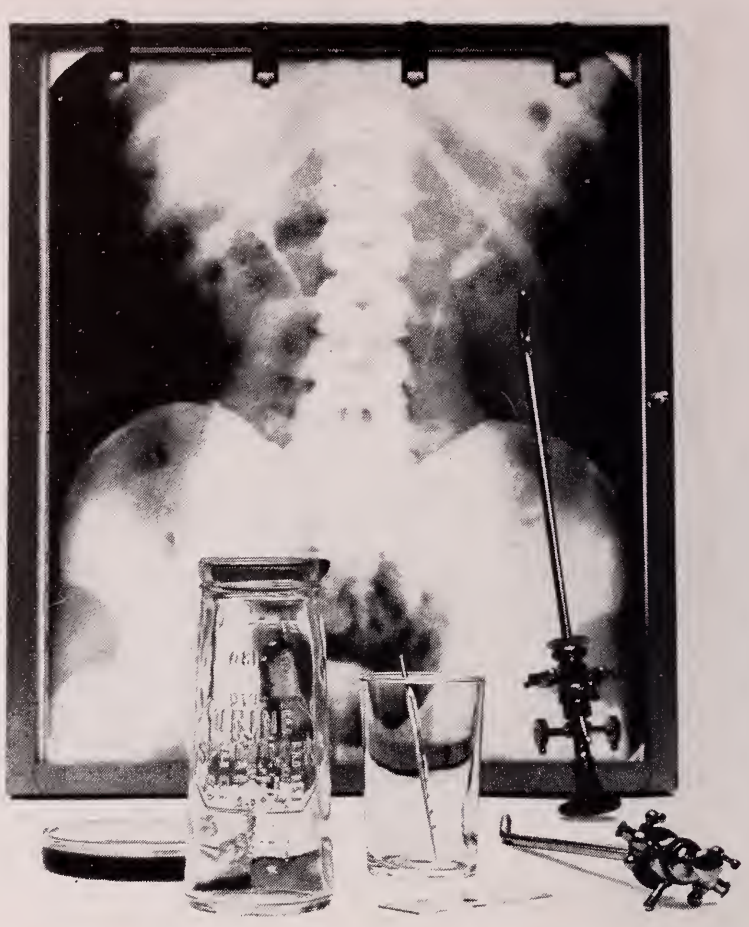
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Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Tatal unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytasteral (predaminantly beta sitasteral)	0.3-0.5%
Tatal tacopherals	0.09-0.12%

Never hydrogenated—completely salt free

when sulfa is your plan of therapy...



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Sulfamethoxypyridazine Lederle



OUTSTANDING 1-DOSE-A-DAY SULFA

Rapid peak attainment in 1 to 2 hours[1,2] . . . approximately one-half the time of other single-daily dose sulfas.[2] *High free levels*—as much as 95 per cent of circulating levels remaining in fully active unconjugated forms.[3] *Extremely low 2.7 per cent incidence of side effects* in toxicity studies on 223 patients.[4] Includes *total* reactions (subjective and objective), all temporary and rapidly reversed. No crystalluria reported.

KYNEX TABLETS, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first day dose of 1 Gm. (2 tablets).

KYNEX ACETYL PEDIATRIC SUSPENSION, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per tsp. (5 cc.). Bottles of 4 and 16 fl. oz.

New **KYNEX** ACETYL PEDIATRIC DROPS, cherry-flavored, 125 mg. sulfamethoxypyridazine activity per cc. In 10 cc. squeeze bottle.

New for acute G. U. infection **AZO KYNEX** TABLETS (for q. i. d. dosage), 125 mg., **KYNEX** Sulfamethoxypyridazine in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

Precautions: Usual sulfonamide precautions apply.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

(Continued from page 357)

Dr. Long is a distinguished member of the Massachusetts and New York Bars and Lecturer in Forensic Medicine at New York University Post-Graduate Medical School. He dedicates this book to Dr. Milton Helpern, Chief Medical Examiner, City of New York, who states in the Foreword that this concise, authoritative, and well documented text is a contribution to a better understanding of many important phases of legal medicine which should be extremely useful to the medical student, the teacher of legal medicine, and the physician in practice.

Jewish Medical Ethics. *A Comparative and Historical Study of the Jewish Religious Attitude to Medicine and Its Practice.* By Rabbi Dr. Immanuel Jakobovits. Pp. 381. Price, $6.00. New York, Philosophical Library, 1959.

This first comprehensive treatise on the subject of Jewish medical ethics, and indeed on the history of religious medical ethics in general, traces the development of Jewish and other religious views on medicomoral problems from antiquity to the present day. It is profusely annotated by references to the original sources in religious, medical, legal and historical literature. The subjects treated include eugenics, sterilization, abortion, euthanasia, anatomical dissection, and the attitude toward faith healing and irrational medical beliefs. Several pertinent chapters are devoted to the physician in Jewish religious law—his studies and privileges, his license and legal responsibilities, his professional charges and the admission of his evidence. The book should be of special interest to physicians, theologians and historians. The author, now a prominent New York Rabbi, was until recently Chief Rabbi of Ireland. He has made frequent contributions on medico-religious subjects to scientific and rabbinical journals in England and America and is an accepted authority on medicine in Jewish law.

Ciba Foundation Symposium on the Regulation of Cell Metabolism. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 387. Illus. 109. Price, $9.50. Boston, Little, Brown and Company, 1959.

This is a very important book. The subject matter represents that next phase of research into the problems of life which must be understood if we are ever going to be able to comprehend the fundamentals of health and disease. Cellular biochemistry is the basis of all metabolic processes, and too little is yet known about it. The 31 reports included in the book deal with fundamentals such as "The meaning of Intracellular Structure for Metabolic Regulation," "Control of Rate of Intracellular Respiration," "Alternative Pathways of Electron Transport," "Mechanisms for Control of Enzyme Synthesis and Enzyme Activity," "Regulation of Growth and Composition of the (Bacterial) Cell," and many others, with the transcription of the lively discussions which each paper provoked among the scientists participating in the three day symposium. Though the language of some of the reports and discussions may be a little above the average doctor's head, no one who peruses the book can help but develop a great deal of respect for the workers who are pioneering the field as well as some healthy curiosity. Carry that curiosity to the point of trying to read any of the papers included and you will find yourself absorbed by the wonderful facts which are slowly coming to our knowledge of cell metabolism and by their multiple possible implications. The many excellent illustrations help a great deal to understand the text better. If not for every old practitioner, this reviewer strongly recommends this book to every young student, graduate or undergraduate. A good portion of the language of medicine in the incoming sixties may be learned there.

C. P. L.

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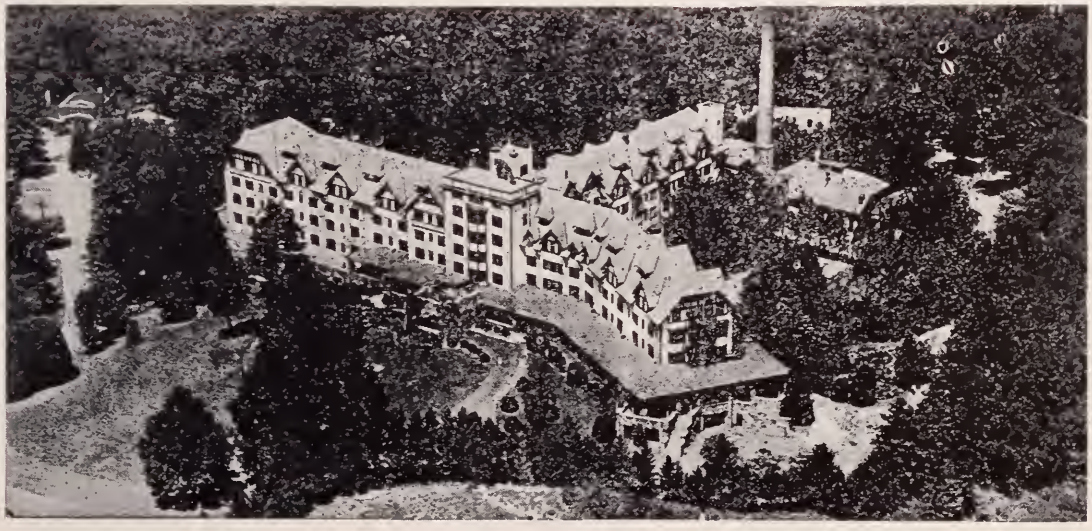
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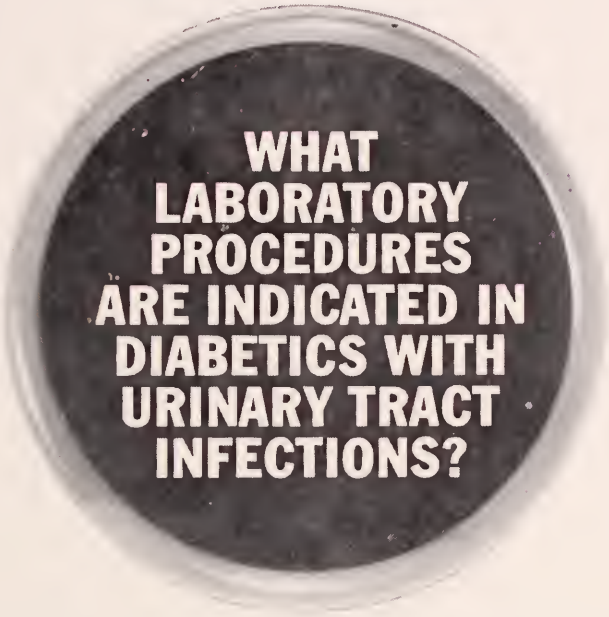
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Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
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Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	37	268
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	111	1034
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	6	359
* *Clay*					
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	258
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st. Wed.	4	34
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Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		38
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Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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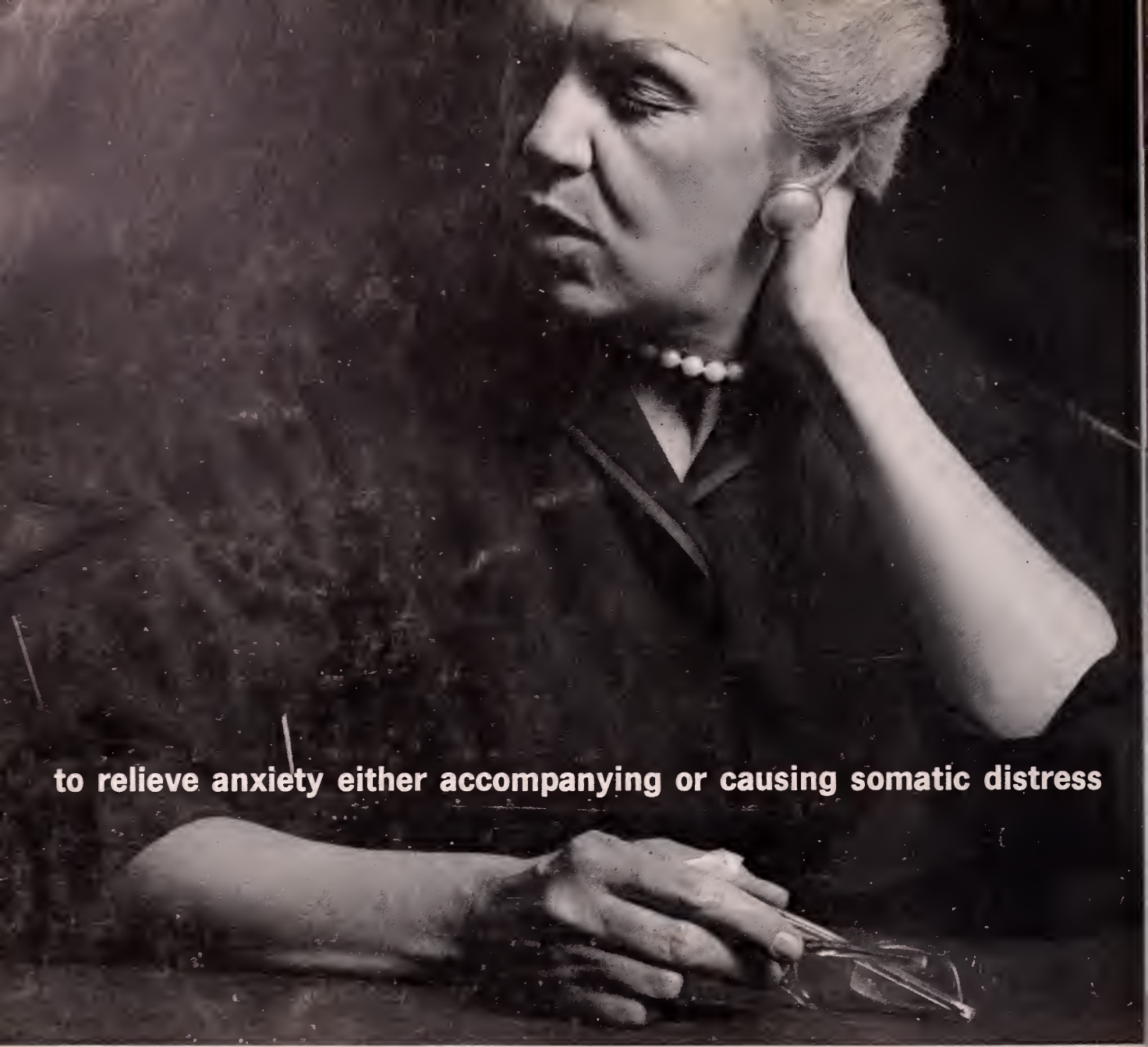
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

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(1) Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132. (2) Crawley, J. W.: M. Clin. North America 42:317 *(March) 1958. (3) Bray, P. F.:* Pediatrics 23:151, *1959.*

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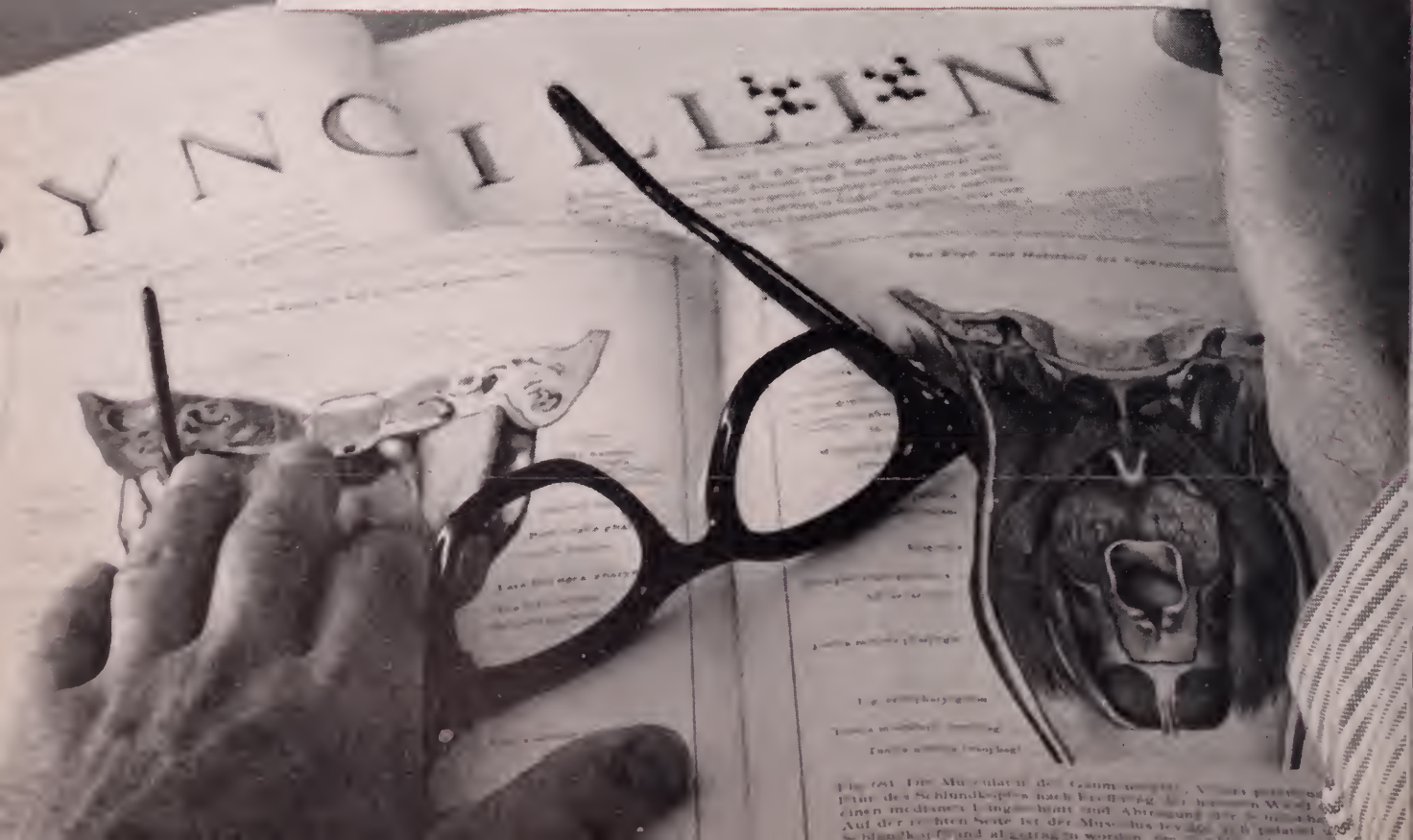
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The Last Word . . .

The Meaning and Challenge Of the 1960 Federal Welfare Law Amendments

H. Phillip Hampton, M.D.
TAMPA

The amendments to the federal welfare laws enacted by the 86th Congress provide more money beginning Oct. 1, 1960 to pay vendors of medical care of all types to needy sick 65 years of age and older.

In order to obtain these federal matching funds the individual states must provide 20 per cent to 50 per cent of the money spent (depending on the per capita wealth—Florida 25 per cent) and institute a medical care program equally applicable in all sections of the state.

For those receiving old age assistance (OAA approximately 70,000 in Florida) the federal government will participate (75 per cent in Florida) in establishing a pooled fund of up to $12 per month per recipient ($10,000,000 in Florida) out of which vendors of medical care to OAA recipients will be paid upon submission of approved vouchers to the state agency administering the fund. "Vendors of medical care" may include hospitals, nursing homes, drugs and appliances, outpatient and inpatient medical services, and visiting home medical care.

This part of the recent amendments is not new, but the amount of federal participating money earmarked for medical care (Kerr amendment) has been increased. Florida now has in operation a vendor payment medical care program for Public Assistance Recipients providing short term hospital care and drugs. The state law permits other medical services, but sufficient funds have not been available. The State of Florida is now appropriating into separate pooled funds to provide short term hospital care and drugs for PAR (approximately 75 per cent used for OAA recipients) at the rate of almost $700,000 this past quarter matched by $1,000,000 of federal funds. Beginning Oct. 1, 1960, if the quarterly contribution to this fund from within the state (not necessarily the state treasury) was increased by $250,000, then $750,000 of federal funds would be added providing an amount sufficient to pay (in addition to the present PAR hospital and drug program) for all medical, hospital, nursing home and outpatient care services to those 65 and over receiving old age assistance, now being provided by individual counties from funds derived 100 per cent through county taxes.

The other part of the amendment to the federal welfare laws by the 86th Congress (Mills amendment) provides federal matching monies to aid in giving medical care only to a new category in the federal Public Assistance program—those 65 years of age and over not eligible for OAA subsistence payments by reason of their personal resources or other reasons, but in need of financial help because of illness as determined by standards established within the state. Our experience in Florida with the Hospital Service for the Indigent program (in operation since 1955) which includes those 65 years of age and over in need of short term hospital care and unable to pay the cost, would indicate a population of about 50,000 people in Florida age 65 years and over eligible for public assistance medical care and not on OAA.

A comprehensive medical care program (hospital care, drugs, outpatient medical care and visiting nurse services) could be provided for all needy sick 65 years of age and over in this state, beginning any time after the first of October 1960, with the federal government paying 75 per cent of costs through existing state laws, if:

1. The county commissioners would agree that all counties appropriate one-half dollar per capita annually from presently budgeted welfare medical funds to match state funds of $1 per capita, the federal matching would provide a fund sufficient to pay all vendors of medical care to the aged needy sick, continuing the present hospital and drugs programs for public assistance recipients to which the state is now appropriating about $1 per capita and the hospital service for the indigent program to which 98 per cent of counties by population are now contributing 50 cents per capita.

2. The State Department of Public Welfare

(Continued on page 411)

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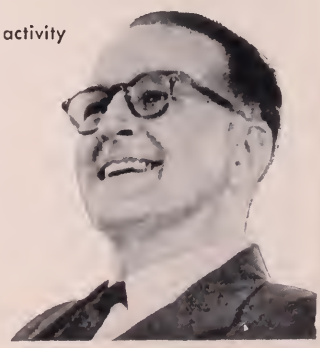
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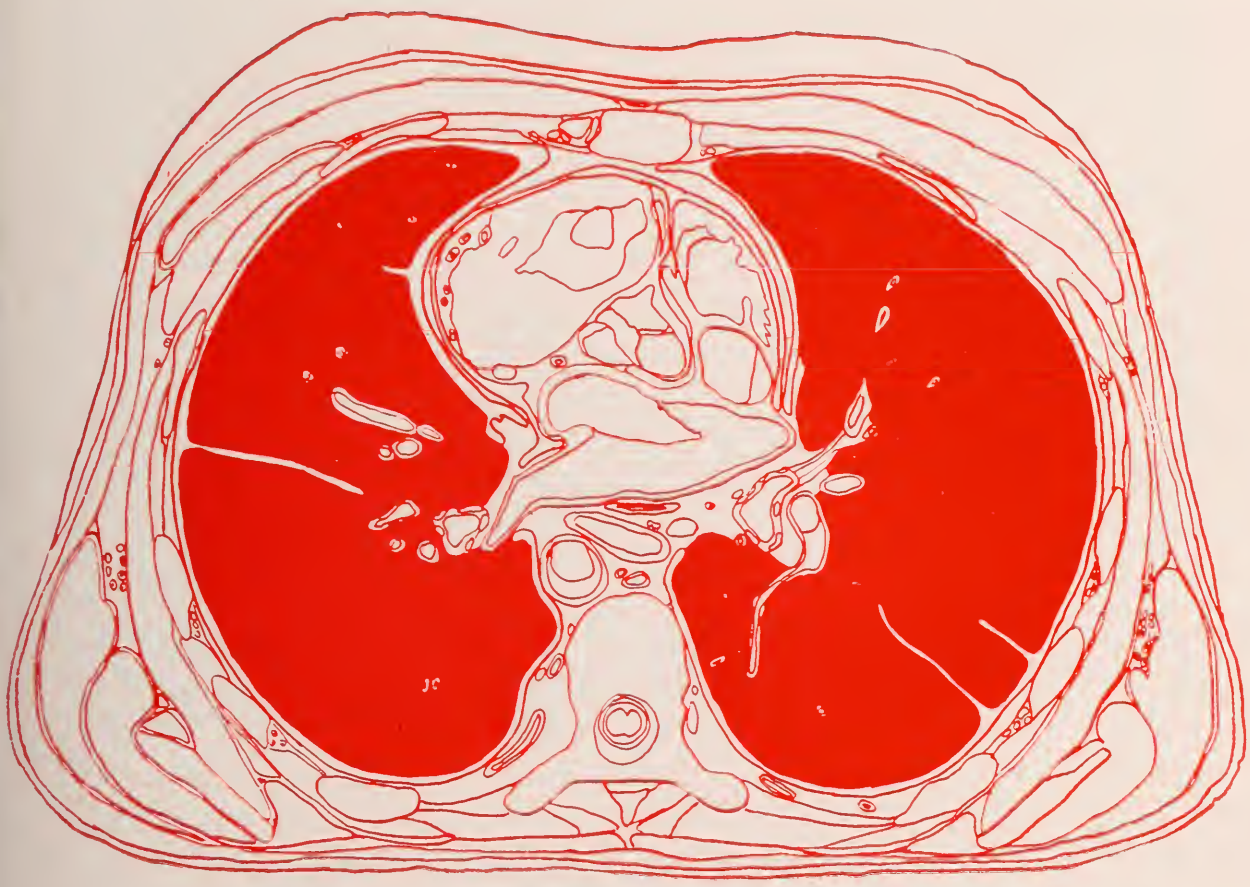
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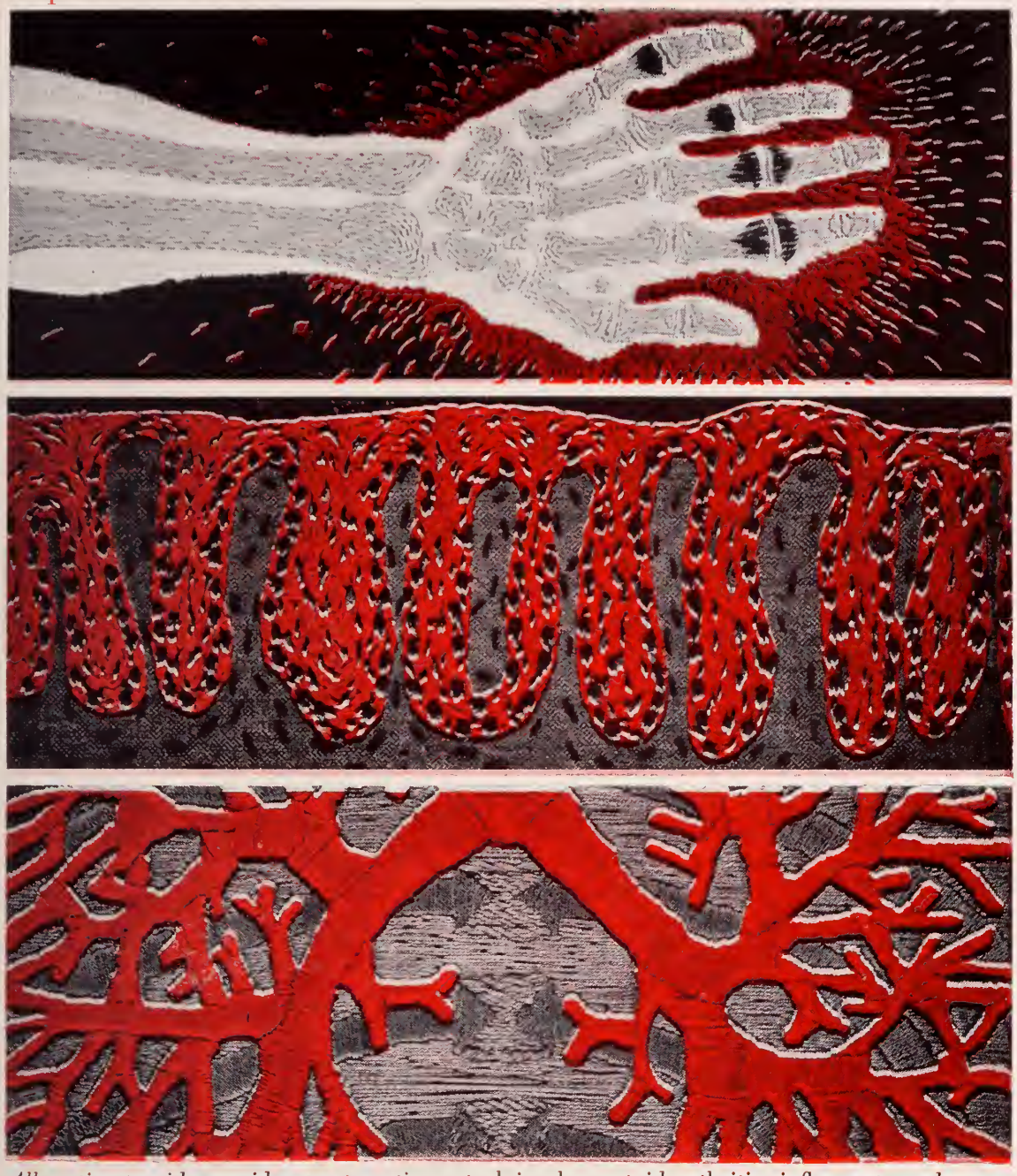
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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVII, No. 4, October, 1960

Therapy of the Systemic Mycoses

JOHN J. PROCKNOW, M.D.
CHICAGO

The systemic or deep mycoses warrant an increasing prominence in the differential diagnosis of acute or chronic infection, particularly when pulmonary involvement is manifest. Intensified therapy with broad spectrum antibiotics, steroids, radiation and antineoplastic drugs, improvement in life expectancy and extensive travel have all served to increase the incidence of systemic fungal disease. The physician must have a high level of suspicion of a deep fungal infection to orient him to that most important matter of making an early diagnosis. It is this early diagnosis which insures effective treatment as a consequence of the immediate application of properly selected therapeutic measures and drugs.

The management and treatment of the deep mycoses are still plagued with ignorance, prejudice, nostrums, toxicities and ineffectiveness. What may be effective against one fungus infection may be completely ineffective against another. Multiple therapeutic agents have been advocated and most have been discarded as they fail to weather the mycotic storm.[1-3] Only a few drugs have proved worth while or specific and they will be briefly reviewed in relationship to those mycoses which they benefit. Conventional supportive measures should always accompany the administration of any specific therapeutic agent in the treatment of systemic infection with fungi. A basic understanding of the nature of the fungal agent and the type of lesion produced aid in the understanding of the reasons for therapeutic success or failure.

Amphotericin B (Fungizone-Squibb)[4] has proved the most promising of any of the antifungal agents discovered to date and, therefore, deserves special consideration. It is the first time that an antibiotic has been termed "broad spectrum" against the fungi. Amphotericin B is a polyene antibiotic produced by a streptomyces strain first isolated in 1955 from a soil sample obtained in Venezuela.[5] It is marketed as a lyophilized yellow powder made soluble by the addition of sodium desoxycholate. The drug is very poorly absorbed through the gastrointestinal tract so that the oral route of administration, as well as the subcutaneous or intramuscular routes, have proved quite ineffectual clinically and of limited value. Demonstrations of its broad fungicidal potency in vitro, its efficacy against experimental mycoses in animals and the increasing numbers of beneficial results being reported in human cases verify that treatment with amphotericin B is successful in histoplasmosis, coccidioidomycosis, cryptococcosis, North American blastomycosis and candidiasis. There has been some beneficial effect noted in the treatment of sporotrichosis, aspergillosis and mucormycosis. An effective serum concentration ranging from 0.5 to 2.0 μg./ml. of the drug against these pathogenic fungi can be obtained only by intravenous administration of the drug.

When definite indications for therapy have been established and the patient has been committed to its use, amphotericin B must be employed at full dosage and with persistence and ingenuity. The course of therapy is initiated with a dosage of 0.25 mg./kg. diluted in 500 to 1,000 ml. of 5 per cent glucose in water given over a six

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hour period and increased by daily increments over a period of one week to an average daily dosage of 0.75 to 1.5 mg./kg. It is imperative that the dosage level of 1.5 mg./kg. per day is not exceeded. To avoid toxicity, the drug may be given on alternate days since an inhibitory concentration in the blood will be maintained for 48 hours. The duration of therapy has not been established, but may vary from many weeks to many months, depending upon the severity and kind of mycotic infection. Overtreatment with amphotericin B should be the rule to insure against relapse. Several factors limit this ideal approach, however. The route of administration, the unpleasant side effects and the need for prolonged therapy all jeopardize a patient's acceptance of the drug.

The impermeability of the meningeal barrier to amphotericin B offers another challenge to its effectiveness in the treatment of mycotic meningitis. In the disseminated mycoses having a predilection for the central nervous system, heroic measures are often necessary. A high serum level of amphotericin B acquired by intravenous infusion provides only a negligible level in the spinal fluid. Intrathecal administration of amphotericin B is, therefore, advocated concomitantly with intravenous therapy to provide inhibitory levels of the drug in the spinal fluid when meningeal involvement has occurred. The level of spinal fluid protein, however, bears some direct relationship with the amphotericin B level following intravenous administration.

The most common acute toxic reactions to amphotericin B are anorexia, nausea, vomiting, chills, fever, headache, malaise, diarrhea, tachycardia and apprehension.[7] They occur more prominently in the early course of intravenous therapy. Anxiety and gastrointestinal symptoms are suppressed by the administration of a sedative or tranquilizer and antiemetic agent. The chills, fever, headache and malaise may be checked by acetylsalicylic acid before and during therapy. Systemic reactions in general can be modified by the use of 10 to 25 mg. of hydrocortisone in each infusion or by antihistaminics given before administration. Any tissue irritation characterized by pain, inflammation or thrombosis at the injection site may be prevented by 20 mg. of heparin added to each infusion. Urinalysis may reveal albuminuria, casts and even hematuria. An elevation of blood urea nitrogen frequently occurs and necessitates discontinuance or lowering of the dosage of amphotericin B. Complete reversibility of the azotemia to normal occurs within a week of drug cessation. Suppression of renal physiology does not always necessarily require discontinuance of the drug because the blood urea nitrogen in many cases may not rise much above 50 mg./ml. in spite of continued therapy. Probable future improvements in this preparation may provide greater ease in administration and decreased toxicity. The saving grace in the imperfections of amphotericin B is the limitation they impose upon its indiscriminate use.

Although there is laboratory evidence that resistance to amphotericin B may develop,[7,8] clinical evidence is lacking to support this view.

Histoplasmosis

Through significant numbers of clinical trials, amphotericin B has proved to be the most efficacious agent in the treatment of histoplasmosis to date.[10-13] Histoplasma capsulatum is inhibited by the small amount of 0.4 μg. of the drug per milliliter of media,[6] and it is highly protective to animals infected experimentally.[14] Acute pulmonary histoplasmosis, a benign infection, frequently encountered in the midwestern United States, is self-limiting and usually warrants no treatment other than supportive measures. The specific indications for therapy in histoplasmosis include (a) severe primary infection, (b) persisting symptomatic infiltrations threatening to disseminate, particularly in infants, (c) mucocutaneous lesions, (d) disseminated infection, (e) chronic pulmonary infection with cavitation, (f) histoplasmosis superimposed upon chronic debilitating disease, and (g) surgical resection.

The most impressive use of amphotericin B has been in the suppression of infection in the disseminated and chronic cavitary forms of histoplasmosis. After a few weeks of treatment, positive sputum promptly converts to negative, accompanied by a marked decrease in the amount of sputum. Although significant symptomatic relief is afforded the majority of patients, roentgenographic evidence of improvement infrequently occurs in the chronic cavitary form of the disease. In cases of disseminated or acute pulmonary histoplasmosis, however, treatment results in rapid improvement in roentgenographic findings. The complement-fixing antibodies generally fall in titer as therapy is continued, but only occasionally reach negative titers.

There is a tendency in chronic cavitary cases of histoplasmosis for relapse to occur with return of symptoms and positive sputum. The chronic fibrosis and extensive necrosis characteristic of chronic cavitary disease prevent the drug from penetrating the lesion at sufficiently high levels to be fungicidal. Amphotericin B is primarily suppressive in this form of histoplasmosis. Consequently, the course of therapy must be as protracted as the patient and the drug permit. Even four to five month courses of intravenous amphotericin B have failed to prevent relapse. Surgical resection of the chronic lesion covered by intravenous amphotericin B offers a successful approach in many cases of cavitary histoplasmosis.

The only other antifungal agents in the treatment of histoplasmosis worthy of mention are the sulfonamides. There have been some doubts cast upon their effectiveness both in experimental and clinical trials. Christie,[15] however, has been successful in achieving remissions in cases of disseminated and mucocutaneous histoplasmosis. Sulfadiazine is preferable and given orally at 6 Gm. daily or in sufficient amount to maintain the blood level at 10 to 20 mg. per hundred milliliters for several months.

Coccidioidomycosis

Amphotericin B is absolutely the first therapeutic agent that has been effective in the treatment of coccidioidal disease.[16-18] It possesses a high degree of activity in vitro against Coccidioides immitis, inhibiting the organism with as little as 0.5 μg. of the drug per milliliter of media.[6] Primary coccidioidomycosis occurs very commonly in the endemic southwestern United States and usually requires no treatment. The true indications for amphotericin B treatment in coccidioidomycosis are (a) severe primary infection, (b) primary infection threatening to disseminate because of known susceptibility of the Negro, Filipino, Mexican and pregnant woman, (c) disseminated infection, (d) skin granulomas and abscesses, (e) negative reactors to the coccidioidin skin test, (f) unstable serology, (g) coverage for surgical procedures.

Since the complement fixation and precipitin tests are of the highest specificity in coccidioidomycosis, they serve as a valuable prognostic guide to therapy.[19,20] If serologic regression to amphotericin B is good, chances of relapse are minimal. If relapse does occur, repeated courses of therapy should be given. The intravenous mode of administration can be combined with intrathecal treatment in cases of coccidioidal meningitis.[18] Surgical resection of chronic cavitary lesions has resulted in significant curative rates with lowering of complement fixation titers. Surgical intervention combined with effective amphotericin B therapy is preferable in the treatment of chronic manifestations of the disease.

Cryptococcosis

It is suspected that many cases of benign cryptococcosis, acquired by the inhalation of dust of pigeon excreta infected with Cryptococcus neoformans, go undiagnosed. The primary lesion develops in the pulmonary tissue, but dissemination may involve all organ systems with a special predilection for the central nervous system. It is in the nervous tissue that the organism proliferates and becomes thickly encapsulated, thus increasing its resistance to the body defenses. Prognosis becomes extremely poor when the nervous system is involved. The earliest possible diagnosis of any cryptococcal infection leading to prompt therapy would provide the greatest chance of cure. Too often, the disease is recognized only after central nervous system involvement has occurred. Without therapy, cryptococcal meningitis will usually culminate in death within four to six months. Spontaneous remissions in this disease have greatly confused the efficacy of multiple therapeutic agents advocated in the past.

Amphotericin B, although admittedly not wholly the ideal therapeutic agent, has been the most promising agent in the treatment of cryptococcosis.[17,21-23] The minimal inhibitory concentration of amphotericin B at 0.03 μg./ml. of media for the cryptococcus fungus is the lowest for all pathogenic fungi.[6] Although the serum levels of amphotericin B effective against Cryptococcus neoformans can be easily attained intravenously, the blood-brain barrier blocks the antibiotic from achieving a concentration sufficiently high to deal effectively with the organism in the spinal fluid. An impressive number of patients, however, with cryptococcal meningitis treated only with intravenous amphotericin B have clinically improved. It may be concluded that even a small amount of antibiotic in the spinal fluid is capable of inhibiting some strains of Cryptococcus neoformans. Relapses frequently occur after prolonged intravenous amphotericin B therapy. Intrathecal injections of amphotericin B have been used successfully in reducing relapse

rates.[10] This method is not without hazards, but does insure a fungicidal level for cryptococcus within the spinal fluid for at least 24 hours after infection.[6] Surgical excision of early localizing lesions still plays an important role in removing any focus for possible dissemination to the central nervous system.

Blastomycosis

North American blastomycosis is a chronic granulomatous disease caused by the fungus, Blastomyces dermatitidis. The primary portal of entry is the respiratory tract, but dissemination may occur to involve other organs of the body, with predilection for skin, subcutaneous tissue, and bone. Blastomycosis can now be classified into (a) primary cutaneous inoculation blastomycosis, and (b) systemic blastomycosis. Both forms require treatment. The aromatic diamidines and amphotericin B are the drugs of choice.

The more stable and least toxic of the diamidine compounds, 2-hydroxystilbamidine, had gained widespread acceptance before the advent of amphotericin B in the treatment of blastomycosis. Numerous case reports attest to the success of this drug.[24-26] A daily intravenous dosage of 225 to 450 mg. is given by slow intravenous drip. The total course of therapy should be between 9 and 12 Gm. The drug may be given continuously or in courses alternating with rest periods. It is thought that 2-hydroxystilbamidine is curative for systemic blastomycosis when sufficient immunologic defenses have been demonstrated by the patient, indicated by the presence of a positive blastomycin skin test and negative complement-fixing antibody titer.[27] Relapses or therapeutic failures with the aromatic diamidines will occur with organisms found to be drug-resistant or in patients who do not demonstrate a favorable immune response.

Amphotericin B is now beginning to appear superior to the aromatic diamidines in the treatment of North American blastomycosis.[28] It is particularly gratifying that successful cures have been achieved in persons who have relapsed following massive therapy with the aromatic diamidines. It has also been noted that a smaller total dosage of amphotericin B is capable of curing blastomycosis than is needed to cure the other systemic mycoses. Furthermore, repeated administration of amphotericin B has not resulted in drug resistance. Surgical excision of localized or chronic blastomycotic lesions should be practiced in carefully selected cases. If pulmonary resection is undertaken for a cavitary lesion, therapy with amphotericin B should accompany the procedure.

Actinomycosis

Actinomycosis, a chronic suppurative mycotic infection, can be classified as (a) cervicofacial, (b) abdominal and (c) thoracic. The latter two forms are decidedly less amenable to treatment. Spread of the infection is by contiguous invasion, resulting in the formation of abscesses which drain through multiple sinus tracts. Extensive fibrosis about the lesions tends to seal off the infection and thus complicates the effectiveness of therapy. The fungus, Actinomyces bovis, is an anaerobe and manifests itself in tissue as a filamentous colony, densely clustered, and offering further resistance to penetration by chemotherapeutic agents.

Penicillin is the drug of choice in the treatment of actinomycosis.[29-31] The actinomyces organism is extremely sensitive to penicillin in vitro. Furthermore, clinical confirmation of the value of penicillin in the treatment of actinomycosis has been overwhelmingly favorable. Frequent treatment failures occurred until more intensive and prolonged periods of treatment were undertaken. When massive doses of penicillin are combined with surgical excision or drainage of infected tissues, notable improvement in the more serious abdominal and pulmonary forms of the disease will usually occur.[31] The dosage ranges from 1 to 6 million units of penicillin daily for several months. Depending upon the severity of the case, the daily administration of penicillin can be increased to 12 million or more units or the period of administration may be prolonged up to a year or longer.

At times, treatment failures occur because of inadequate therapy, resistance of the organism, or sensitivity of the patient to penicillin. Even discounting these factors, the use of huge doses of penicillin may not arrest the disease process. In vitro sensitivity studies provide the best means of selecting a supplemental or substitute agent for penicillin. Erythromycin is one of the most effective antibiotics next to penicillin. The broad spectrum antibiotics, namely, the tetracyclines and chloramphenicol, are also active drugs against the actinomyces and cures have been reported with their use alone or in combination with other agents. Streptomycin and the sulfonamides are the least effective. Iodides have almost

completely lost their claim to fame in the therapy of actinomycosis. The surgical drainage or excision of infected tissue plays a very important role in the success of antibiotic therapy.

Nocardiosis

Nocardiosis is a fungus infection which is closely akin to actinomycosis. The pulmonary tract also serves as the usual portal of entry, from whence hematogenous spread occurs with predilection for the brain and subcutaneous tissues. Although the infection is chronically suppurative, it is less likely that sinus tracts and abscesses will form. Like Actinomyces bovis, nocardia is a bacterial-like fungus, but grows aerobically on many laboratory media. The organism may easily be confused with Mycobacterium tuberculosis because it often segments into short fragments and is frequently acid-fast.

Infection with the nocardia organism is more difficult to treat than actinomycosis because of greater severity of the infection and greater resistance of the organism. Sulfadiazine is the drug of choice in the treatment of nocardiosis.[31,33] In many clinical trials, recovery in nocardiosis was achieved only when the sulfonamides were added to other forms of therapy. The dosage of sulfadiazine ranges from 4 to 8 Gm. or more daily, or an amount sufficient to maintain a blood level of 10 to 20 mg. per hundred milliliters depending upon the severity of the infection. Since nocardia is quite resistant to therapy, sulfadiazine combined with streptomycin or a broad spectrum antibiotic offers a better chance of cure. Antibiotic therapy must be vigorous and prolonged for several months to several years to insure healing.

The choice of any supplemental antibiotic is usually based upon sensitivity tests, but such tests against nocardia have proved to be misleading. The broad spectrum antibiotic is given in the dosage of 2 Gm. per day. Surgical procedures to insure adequate drainage of abscesses and excision of locally infected tissues must augment the chemotherapeutic approach to nocardiosis. Furthermore, treatment with sulfadiazine alone or combined with an antibiotic should accompany all operative procedures.

Candidiasis

The fungus, Candida albicans, is an ubiquitous saprophyte existing normally in man within the mouth, gastrointestinal tract and vagina and on the skin. It can cause superficial infections of these tissues as well as assume the role of a serious pathogen in its invasion of the gastrointestinal mucosa and the bronchopulmonary system and then ultimately disseminate. The predisposing factors to systemic candida infections are debilitating diseases, infancy, diabetes mellitus, pregnancy, poor nutrition, obesity and chronic pulmonary disease.

Both nystatin and amphotericin B are equally effective antibiotics against Candida albicans by in vivo and in vitro studies.[5,34] The poor absorption of nystatin from the gastrointestinal tract limits its usefulness in the treatment of pulmonary or disseminated forms of candidiasis. Since it is very effective upon direct contact with the candida organism, available topical and oral formulations will cure the localized oral, cutaneous and vaginal infections and suppress gastrointestinal infections. In combination with tetracyclines it has gained acceptance in the prevention of monilial superinfection which might arise from prolonged broad spectrum antibiosis.

The drug of choice in the treatment of pulmonary and systemic candidiasis is amphotericin B.[1] The lowest minimal inhibitory concentration of the agent for Candida albicans is 0.5 μg./ml. of media.[6] Oral amphotericin B is also effective in gastrointestinal candidiasis.[35,36] The supplementing of oral or local forms of amphotericin B and nystatin with parenteral amphotericin B will provide intensive therapy for the most serious candida infections.

Methylrosaniline chloride (Gentian violet) was successfully used topically and intravenously for candidiasis before the advent of nystatin or amphotericin B. It is mentioned only as an alternate therapy to the newer agents.

Aspergillosis

Most cases of aspergillosis are caused by Aspergillus fumigatus. As a primary or secondary invader of lung tissue, it is most frequently associated with predisposing factors such as debilitation or diabetes. Secondary infection with aspergillus is commonly superimposed upon an antecedent pulmonary disease.[37]

Since no specific drug therapy has been particularly effective, the treatment of choice in localized pulmonary aspergillosis is surgical resection or drainage of focal infection.[38] The careful clinical control of the predisposing diseases is also very important.

Of the antifungal antibiotics, nystatin and amphotericin B deserve mention. Amphotericin B, in particular, needs further evaluation. Although the inhibitory effect of this drug on the aspergillus organism is insignificant by in vitro studies, in vivo studies on rabbits showed suppression of lesions in the treated animals.[39] Some, but all too few, clinical trials with amphotericin B have produced encouraging results.[17] Effective therapy with nystatin has been produced when administered intrapleurally or by inhalation in a few cases.[10-12]

Sporotrichosis

Sporotrichosis is often a chronic fungal infection caused by Sporotrichum schenckii. Infection is usually limited to the skin and subcutaneous tissues, but dissemination may occur to involve many organs.

Iodides are specific in the treatment of sporotrichosis, particularly in the localized and lymphatic form of the disease.[43] The disseminated forms of sporotrichosis, however, have been less responsive to iodide therapy. Iodides should be tried first as treatment for any form of sporotrichosis, nevertheless, and for sufficiently long periods. Response is slow, but quite often satisfactory, to the oral administration of a saturated solution of potassium iodide. It is prescribed in the initial dose of 3 to 5 drops given three times daily and increased by daily increments of 1 to 3 drops per day up to a total of 40 to 50 drops three times daily. Clinical evidence of improvement will generally be noted within a few weeks to a few months, but iodide therapy should be continued for at least another month after apparent cure is attained.

In those patients with generalized sporotrichal involvement unresponsive to iodide therapy or who are sensitive to iodides, a course of therapy with either 2-hydroxystilbamidine or amphotericin B is indicated. Both the aromatic diamidines[14] and amphotericin B demonstrate good in vitro effectiveness against Sporotrichum schenckii. The yeast phase of the organism is inhibited by amphotericin B in the small amount of 0.07 μg./ml. of media.[6] Sufficient curative value in a few cases of systemic sporotrichosis has been shown with these two drugs to warrant a clinical trial when iodides fail.[6,15]

Mucormycosis

Mucormycosis is a rare fungal disease entity and is caused by fungi of the Mucor, Rhizopus, and Absidia genera. Being very widely distributed in nature, these organisms can gain entrance primarily into the respiratory tract. There is a true predilection for persons suffering from uncontrolled diabetes mellitus. The only measure advocated thus far has been the careful control of the diabetic state which predisposes to the disease. Amphotericin B again shows possibility as the therapeutic agent in the treatment for mucormycosis and should be explored further. Recent studies in experimentally infected rabbits have shown very significant protection against lethal doses of Rhizopus spores and suppression of disseminated lesions.[46,47]

Conclusion

The treatment of systemic mycotic infections has at last achieved a bright outlook. Amphotericin B must be credited with a spectacular record in the broad approach to specific antibiotic therapy against multiple fungal agents. We can continue to hope that modifications in this therapeutic agent will decrease its toxicity and that our present recognition of increasing numbers of systemic fungal infections will culminate in the discovery of newer and better agents.

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Traditionally, the pool swimmer is susceptible to eye, ear, nose and throat infections. Such skin infections as ringworm, schistosomiasis and scabies, and also gastrointestinal disorders, have less frequently been recorded. These may spread from one bather to another, or may be caused by contaminated water and unsanitary bathing appurtenances such as walkways, towels and suits.

Medical literature on other diseases incurred in swimming pools is scarce. Surveys from time to time by public health organizations, both national and state, have yielded little concrete information and few authenticated case histories. State health officials, polled in 1955 by the American Public Health Association, reported no authenticated cases of disease of swimming pool origin in 45 of the 48 states and one territory.

Occasional cases of skin eruptions on the bodies of bathers have been observed. In Wisconsin and Michigan studies have been made of the incidence of "swimmer's itch," or schistosome dermatitis, which has affected bathers in waters infested with Schistosoma haematobium, the invertebrate host being small snails of several genera.

From reports in the recent literature it appears that abrasive accidents in swimming pools have given rise to a new clinical entity known as swimming pool granuloma. Such accidents may occur in diving, in underwater swimming, or in getting in and out of the pool. Reports from Europe, Canada and various parts of the United States indicate widespread geographic distribution of this entity. The purpose of this paper is to discuss this granulomatous infection and to present four cases, believed to be the first reported from Florida or the Southeastern United States.

Review of Literature

In 1951, Hellerström[1] reported six cases he had observed between 1939 and 1949;[2] all were associated with swimming pool injuries, five of the patients having used the same pool, and in all the strikingly uniform clinical features led to a diagnosis of inoculation lupus vulgaris. Some laboratory confirmation of this diagnosis prompted him to call on dermatologists, as well as tuberculosis control officers and sanitary engineers, to give attention to tuberculosis as a water-borne infection.[3] Also in 1951, from Canada, Cleveland[4] reported four cases of possible primary tuberculous infection of the skin complicating abrasions sustained in a public swimming pool in Vancouver. Although laboratory confirmation was lacking, he regarded the clinical and histopathologic appearance of the lesions as highly suggestive of this disease.

Brück,[5,6] in 1951, reported two cases of inoculation vulgaris associated with swimming pool injuries and a third the following year. Nordén and Linell[7,8] made their first report in 1951 and in 1954 published a comprehensive monograph on the subject in which they reviewed the epidemic of 80 cases in one Swedish city, reported the previous year by Herlitz,[9] many of which they had studied. They cited Zettergren,[10] who reported six skin lesions following swimming pool injuries similar clinically to theirs, observed elsewhere in Sweden.

In the United States, Tolmach and Frank,[11] in 1953, described a case observed by them in New York City in which abrasion in a swimming pool accident resulted in an infection diagnosed as granuloma of the skin with tubercle formation. Later that year, Rees and Bennett[12] reported nine cases from San Francisco associated with swimming pool abrasions and diagnosed as tuberculosis verrucosa cutis. They cited Shaw, who in a personal communication reported treating 10 or 12 patients with granulomatous lesions, all of whom sustained abrasions in a swimming pool in Seattle. They estimated 26 to 28 cases had been recognized on the North American continent by 1953. From Texas in 1954, Richardson and Seale[13] reported one case of granuloma following superficial abrasion sustained on the concrete apron of a swimming pool.

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Etiologic Factors

In one of Hellerström's cases there were acid-fast bacilli in the lesions, and the tubercle bacillus was isolated from a pool used by one of the patients. Although the appearance of the lesions and the histologic findings were consistent with lupus vulgaris, results of guinea pig inoculations and of roentgen examinations of the chest were negative. In four of the cases, however, there was slight enlargement of the regional lymph nodes, and in all six of the patients the tuberculin reaction was positive although in five it had been negative before the injury. Hellerström[1-3] was convinced that the lesions in his cases were manifestations of primary tuberculosis of the skin because of the absence of tuberculous foci elsewhere and the conversion of the tuberculin reactions. In Cleveland's cases, no acid-fast bacilli were demonstrated in the lesions, but clinical and histologic evidence suggested tuberculosis of the skin. Cleveland[4] suggested the possibility of contamination of the swimming pools by persons with incipient or minimal tuberculosis of the lungs or genitourinary tract. In commenting on the reports of these authors in 1952, Sulzberger and Baer[14] questioned the etiology and commented that the smegma bacillus, which may be present in pools in large numbers, produces a "tuberculoid type of response."

In their monograph, Linell and Nordén[8] in 1954 summarized previous studies and concluded that Koch's bacillus was not the etiologic agent. They isolated a previously unrecognized Mycobacterium similar to Koch's bacillus, which they named balnei. They were able to isolate this gram-positive, strongly acid-fast organism from both the water and the walls of the swimming pool associated with the epidemic and to prove conclusively by laboratory studies on animals and on human volunteers that Mycobacterium balnei was the causative organism. By rubbing cement from the pool wall into the skin of a rabbit, they were able to produce tissue changes similar to those in the human lesions. They observed in some preparations a tuberculoid structure, sometimes with central fibrinoid necrosis. Although staining revealed no organisms, in cultures acid-fast organisms were indistinguishable from tubercle bacilli. The organisms were only slightly pathogenic for guinea pigs, but in mice intraperitoneal injections produced ulcerations along the tail and swellings and ulcerations of the feet that were filled with acid-fast bacilli. Histologically, most of the lesions were granulomatous, acid-fast bacilli being demonstrated in but one case.

In the cases of Zettergren,[8,10] attempts at demonstrating tubercle bacilli were unsuccessful. This author regarded Mycobacterium marinum, or a closely related species, as the probable etiologic agent, but Linell and Nordén[8] isolated Myco. balnei from lesions and from the pool. Mycobacteriosis balnearea was the name given to the syndrome.

In the case reported by Brück[6] in 1952, the clinical diagnosis of lupus vulgaris was confirmed when tubercle bacilli were cultured from the lesions and subsequently produced tuberculosis in guinea pigs. These findings led Brück to conclude that mycobacteriosis balnearea, or "so-called swimmer's lupus," could be caused by Mycobacterium tuberculosis and by Myco. balnei. He regarded the former as the responsible organism in his 1952 case and the cases of Hellerström,[1-3] and the latter in the cases of Linell and Nordén[8] and Zettergren.[8,10] After reviewing all available reports of cases, Hellerström[3] concurred in Brück's conclusion regarding similar clinical manifestations caused by different etiologic agents, but he rejected Myco. balnei as the responsible agent. He thought that the organism isolated by Linell and Nordén[8] might be a mutant of Myco. tuberculosis, or that it might be Myco. marinum, as Zettergren[8,10] suggested.

Tolmach and Frank[11] described the lesions in their case as skin granuloma with tubercle formation of unknown etiology. In the cases of Rees and Bennett[12] eight of the nine patients used the same pool, and most of them had a positive tuberculin reaction after the injury. These authors ruled out granuloma due to silicates and deep fungus infections and mentioned the possibility of Myco. tuberculosis or the smegma bacillus as the causative agent, although neither was demonstrated in the lesions or in the pool. In four of the cases guinea pig inoculation yielded no evidence of tuberculous infection. They noted that Shaw[12] did not regard the lesions in his cases as tuberculous because laboratory proof was lacking and because healing took place within a few months. They concluded that these relatively uncommon lesions were benign and somewhat self-limited in nature.

In the case of Richardson and Seale,[13] the histopathologic diagnosis was chronic granuloma, possibly tuberculosis. Regarding the eruption as an infectious process, they suggested that, in

future, cultures be made on several different types of mediums at varying temperatures in an attempt to determine the causative agent.

In their comment on the monograph of Linell and Nordén,[8] Sulzberger and Baer,[15] in 1955, declared it to be a "masterly clarification of a relatively new entity apparently caused by a quite newly discovered acid-fast mycobacterium (M. balnei.)" They considered it virtually certain that this entity was identical with that previously described by Hellerström[1-3] in Sweden, Cleveland[4] in Canada and Rees and Bennett[12] and Tolmach and Frank[11] in the United States. Expressing small wonder that this infection had been diagnosed as a form of tuberculosis in the past, they considered it likely that the uninitiated would continue in this error in dealing with many future cases.

Site and Appearance of the Lesion

Since abrasions incurred in swimming pools usually involve the bridge of the nose, the elbows or the knees, these were the common sites of the lesions in the cases reported in the literature. In Hellerström's cases the patients were males ranging in age from 14 to 29 years, and the eruption developed on the bridge of the nose three to six weeks following the abrasion, which in most cases had healed. The lesions were soft, reddish brown papules similar in diascopic appearance to lupus vulgaris; some were crusted and coalesced. They varied in size "from a pinhead to a spilt pea."

Linell and Nordén[8] described the lesion in their cases as of spongy consistency and located on the outside of the elbow in almost every case. It was slow-growing, became ulcerated, eventually crusted with thick secretion developing under the crusts, and healed spontaneously in six to 24 months. When purulent infection was a complication, the healing process was especially prolonged. A bluish red, soft scar remained, and there was scaling of the surrounding skin.

In the case reported by Tolmach and Frank[11] the site of the abrasion was the bridge of the nose, and the lesion, approximately 2.5 cm. in diameter, in general resembled those described by Hellerström.[3] It was a dull reddish brown granulomatous eruption with distinct margins, and diascopic examination revealed yellowish brown nodules. The entire lesion had a definite firmness and was studded with papulopustules. The patients of Rees and Bennett[12] ranged in age from eight to 20 years, and all but one used the same pool. The site of the lesion was the knee in seven, the right index finger in one, and the front of the ankle in one; in Shaw's patients it was the knee, elbow and nose. These authors pointed out that the lesions in their patients differed sharply in one respect from those of Hellerström,[1-3] Cleveland,[4] Brück[5,6] and others in that they were typical clinically of tuberculosis verrucosa cutis while those previously reported were of the lupus vulgaris type. They stated that lupus vulgaris is a rarity in California. Hellerström, they noted, stressed the fact that his cases were not those of ordinary lupus vulgaris but seemed to result from a superficial inoculation of the skin with the tubercle bacillus, bypassing a violent primary tuberculous complex of the skin. In addition, they thought it should be emphasized that the lesions reported by Hellerström[3] occurred on the nose and were clinically those of lupus vulgaris while those reported by Nordén and Linell[7] and Zettergren[10] were on the elbow and were ulcerated. The lesion was on the elbow in the case of Richardson and Seale.[13]

Treatment

Irradiation with ultraviolet light, Finsen lamp exposures, oral calciferol, and in one case p-aminosalicylic acid were the therapeutic measures employed by Hellerström.[1-3] The lesions healed in three to nine months. In Cleveland's cases the lesions responded to roentgen therapy within three to five months, although destruction with solid carbon dioxide was necessary for residual lesions in one case.

Rees and Bennett[12] used calciferol by mouth, conservative roentgen therapy and, in two resistant cases, isoniazid, which promptly cleared the lesions; healing took place within three to six months. After there was no improvement on treatment with calciferol for five weeks in their case, Tolmach and Frank[11] changed to Promin (di-sodium p, p-sulfonyldianiline-N, N′- diglucoside disulfonate) jelly applied locally for five weeks with good response and then to lotio alba with healing complete five months later. In the case of Richardson and Seale,[13] destruction of the lesion by curettage and electrodesiccation resulted in healing with the formation of a soft pliable scar.

Report of Cases

Case 1.—A 12 year old boy was first seen on Oct. 5, 1956, complaining of a "sore" on his left knee present "all summer" since scraping his knee getting out of a

swimming pool in June. The lesion appeared to heal spontaneously, to be followed about three weeks later by the appearance of several "red bumps," each about the size of a pea. These had grown and coalesced to form a nodule 2 cm. by 1 cm. (fig. 1). The summit of each nodule was ulcerated to varying depths and the tops were crusted. A punch biopsy was obtained and sent directly to the bacteriology laboratory for direct smear and culture. No pathogenic fungi or acid-fast organisms were found on October 5 or November 11. A tuberculin test on this date was negative. From a third culture on December 10, however, an acid-fast rod similar to the tubercle bacillus was isolated. It did not grow at 37 C. on Löwenstein-Jensen medium, and guinea pig inoculation was negative. This organism was identified by the bacteriologist as M. balnei. A repeat tuberculin test on the patient was now positive.

Topical treatment consisted of application of wet compresses of Burow's solution 1:30 for thirty minutes twice daily and the application of an antibiotic ointment dressing at bedtime. The patient was given Dihydrostreptomycin one-half Gram intramuscularly daily for five days and during the succeeding three weeks two other courses of this drug were given for five days without effecting any change in the lesion. A punch biopsy was obtained from the lesion on October 19, and the microscopic picture described by one of us (N.A.M.) was as follows:

"Specimen consists of a disc-shaped, grayish white, solid piece of tissue 4 mm. in diameter and 3 mm. thick. Sections show a covering of mature squamous epithelium. In some areas the epithelium is thickened. An occasional epithelial downgrowth is present, but these areas are fully mature. Just beneath the epidermis is a circumscribed mass of neutrophiles. Additional scattered neutrophiles are seen in other areas. A few epithelioid cells are seen at the edge of the neutrophilic mass, but no definite tubercles are seen and no foreign body type giant cells can be demonstrated. Examination of the tissue under oil immersion fails to show any parasites. The histologic picture and location are suggestive of the so-called "swimming pool" granuloma. There is no evidence of malignancy.

"Diagnosis: Knee: Inflammatory Granulomatous Reaction, benign (compatible with swimming pool granuloma.)"

On October 30, a smear and culture taken directly from the raw surface of a papule resulted in the isolation of several organisms of the Aerogenes group, a hemolytic staphylococcus aureus and an additional strikingly acid-fast organism finally identified as Mycobacterium balnei. Thus, the diagnosis was established of our first case of swimming pool granuloma. On November 19, isoniazid was started orally in a total daily dose of 8 mg. per kilogram of body weight subdivided in three doses in milk after meals. This therapy was continued until November 30, after which time the patient was lost from our observation. During a conversation with the boy's father it was learned that without further treatment the lesion was still present and approximately one-fourth its maximum size by March 1, 1960, nearly four years after it was incurred.



Fig. 1.—Swimming pool granuloma of approximately four years' duration on the knee of a 12 year old boy.



Fig. 2.—Swimming pool granuloma of 7 months' duration on the knee of a seven year old girl.

Case 2.—A 15 year old white girl was first seen on March 19, 1958, because of a granulating lesion of seven months' duration situated over the extensor surface of the left knee. The lesion was approximately the size and shape of a kidney bean, spongy in consistency and covered with a purulent discharge. This nodule covered the site of a superficial abrasion sustained on her left knee as she climbed out of a swimming pool "late in August" 1957. Punch biopsy was described by the pathologist as follows:

"Specimen consists of a single, disc-shaped, grayish brown, solid piece of tissue 4 x 4 x 1 mm. Sections show the covering epithelium to be thickened and cornified. There is some hypertrophy of the epithelial pegs. The basement membrane is poorly demarcated in some areas. The deeper portions contain numerous leukocytes. A few circumscribed masses of epithelioid cells are seen. There is no evidence of malignancy.

"Diagnosis: Right Knee: Inflammatory Granulomatous Reaction, benign (compatible with swimming pool granuloma.) Tuberculin test was negative."

The patient returned to the office for treatment at irregular intervals and received 250 mg. of streptomycin intramuscularly on April 15, April 29, and May 2. On May 16, 250 mg. of Chloromycetin was given intramuscularly. No other treatment either local or systemic was given. On June 10, the child's mother telephoned that the lesion was completely healed with a barely perceptible scar.

Case 3.—An 18 year old college student was seen on Dec. 23, 1958, during his Christmas vacation because of a crusted plaque on the flexure surface of the left forearm.



Fig. 3.—Microscopic picture of swimming pool granuloma. Note hyperkeratosis, parakeratosis and infiltrates in the corium composed of "epithelioid" cells intermixed with round cells and tendency to tubercle formation.

He stated that in July 1958 he had sustained a "scratch" or a "rope burn" while playing water polo in a pool. The lesion was crusted for several months and would not heal. When first seen on December 23 the boy showed a crusted plaque the size of a five cent piece. There was a central depression or crater 4 mm. in diameter containing a small quantity of cloudy fluid. The borders were raised, translucent, and of soft spongy consistency. Under local infiltration anesthesia the entire lesion was easily removed by curettage and fixed in formalin for laboratory examination. The microscopic findings were typical of swimming pool granuloma. Healing with a smooth noncontracted scar was complete in four weeks.

Case 4.—A child was seen for the first time on Jan. 16, 1960, at the age of six and one-half years. She had been swimming in a public pool only one time in her life on March 31, 1957, but habitually swam in a makeshift swimming area in the St. Johns River near her home in an area protected by the arrangement of large stones and pieces of old cement blocks.

For approximately seven months prior to the first examination of the child her mother had noted "two small bumps" on the extensor surface of her right knee, first seen as two small papules each a little larger than the head of a pin. On Jan. 16, 1960, each of these papules was approximately the size of a pea. The surrounding integument was scaling. The papules were translucent and crusted; beneath the crust was a crater 3 mm. in diameter containing a fairly thick clear fluid apparently of high viscosity as it did not flow over the edge of the crater. Swimming pool granuloma was suspected. The child returned on February 6, by which time the two papules had coalesced (fig. 2). The patient often picked off the crust, which promptly reformed. At this stage a punch biopsy was obtained on February 6, and was described as follows:

"Specimen consists of a single, solid, grayish brown piece of tissue 4 x 3 x 1 mm. Sections show the covering epithelium to be cornified. There is some downgrowth of the epithelial pegs. Some follicular plugging is noticed. An occasional mass of epithelioid cells forming tubercle-like structures is seen. Rather numerous leukocytes of all types are present beneath the surface. An occasional multi-nucleated giant cell is seen. There is no evidence of caseation. Acid-fast infection is to be considered, but I would favor the diagnosis listed below. There is no evidence of malignancy.

"Diagnosis: Right leg: Swimming Pool Granuloma, benign. Direct smear was negative for acid-fast organisms; culture is in progress."

Comment

Two decades ago, the late Dr. H. Marshall Taylor,[16] in reporting his extensive research here in Florida on the health hazards of swimming, wisely observed: "Man is a terrestrial animal and contracts infections in water. . .that run the gamut of pathologic conditions from the innocent circumscribed furuncle to a disease condition of the mastoid." He referred to the field of the otorhinolaryngologist, but his statement has wider application. Mycobacteriosis balnearea appears to be a new hazard which should evoke year-round interest in Florida.

Microscopic Picture.—The cutaneous lesions are located mainly in the corium. The changes seen in the epidermis are probably secondary. Some lesions show moderate hyperplasia of the epidermis with acanthosis. The surface is frequently covered with parakeratotic scales. Sometimes the epithelium has been replaced by fibrin crusts containing polymorphonuclear leukocytes. The epithelial changes are not sharply demarcated but gradually merge with the surrounding normal epidermis (fig. 3).

The corium is usually the site of widespread inflammatory changes which are located in the region just beneath the epidermis and seldom extend below the level of the sweat glands. In a few cases, however, the lesions have broken deeper into the corium.

The lesions themselves are characterized by varying sized infiltrates, dominated by fairly large cells with vesicular nuclei containing nucleoles. These cells have abundant, pale-staining, foamy cytoplasm and vary widely in shape; polygonal, stellate and spindle-shape cells are seen. The large histiocytes or "epithelioid" cells are often intermixed with round cells, mainly lymphocytes. Polymorphonuclear leukocytes and fully differentiated plasma cells are rare. Eosinophil leukocytes are extremely rare. Staining with methylene blue will bring out some scattered mast cells with metachromatically staining violet granules. On the other hand, a fairly large number of giant cells may be

seen. Many of them are of the Langhans type, but smaller giant cells with only a few nuclei, usually located near the margin, are also often seen. The cytoplasm of the giant cells is foamy and pale-staining. Of all the cytological elements, the histiocytes and round cells are by far the most common (fig. 4). They appear in varying proportions, but the histiocytes show a marked tendency to form accumulations which give the inflammatory process a granulomatous character. The epithelioid cells sometimes appear in rounded, discrete, tubercle-like foci (fig. 5). In addition to these inflammatory changes, more or less characteristic of what is generally known as granulomatous inflammation, are infiltrates of histologically nonspecific character. For instance, cellular infiltration around the superficial vessels in the corium or around sweat glands is common. The endothelial cells of the vessels in the center of these infiltrates are swollen.

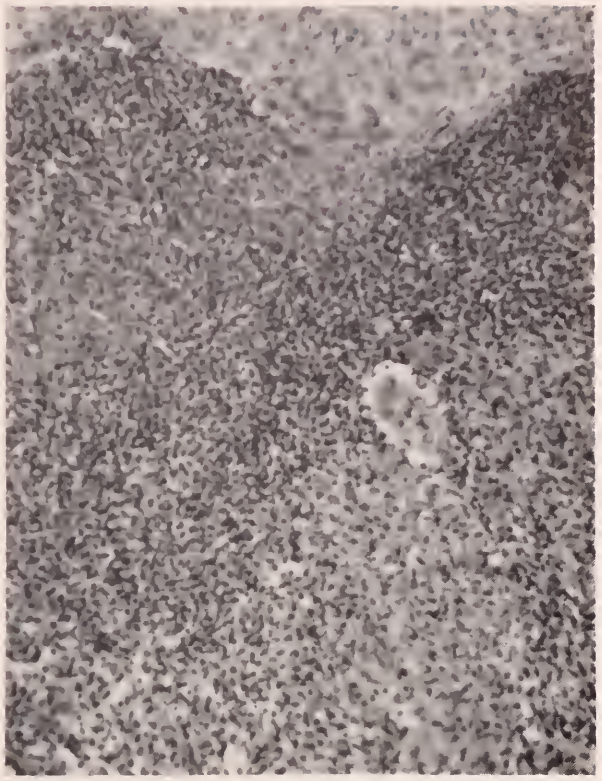


Fig. 4.—Microscopic picture showing typical round cell and epithelioid cell infiltrate in the corium. Note giant cell near center of field.

Macroscopic Morphology of Mycobacterium Balnei.—The morphology of the colonies has been very regular on Löwenstein-Jensen medium with incubation at 31 C. Typical colonies appear after nine to 12 days. They are whitish yellow, moist and glistening, rather flat with a central elevation. The edge is slightly irregular. Sometimes radiation folds are noted and sometimes the flattening out occurs in the shape of low terraces. Both "rough" and "smooth" colonies have been found.

Microscopic Morphology.—This is a strikingly acid-fast organism. It is a slender rod, closely resembling the tubercle bacillus, measuring 1.5 to 2.5 microns in length and 0.2 to 0.4 microns in diameter. The shape may vary, and sometimes small, almost coccoid forms have been observed. Occasionally the rod is slightly bent.

Prophylaxis.—While pool-borne diseases are encountered with relative infrequence, the growing popularity of public and home swimming pools, reflected by an estimated increase from 10,000 in 1946 to 132,000 today,[17] confronts the physician with new problems in sanitation and health. The rapidly increasing number of residential pools, which are usually made of concrete and which are not under public health control, is potentially not an insignificant factor in raising the country's morbidity statistics. The newly recognized clinical entity of swimming pool granuloma is a case in point. It deserves the considera-

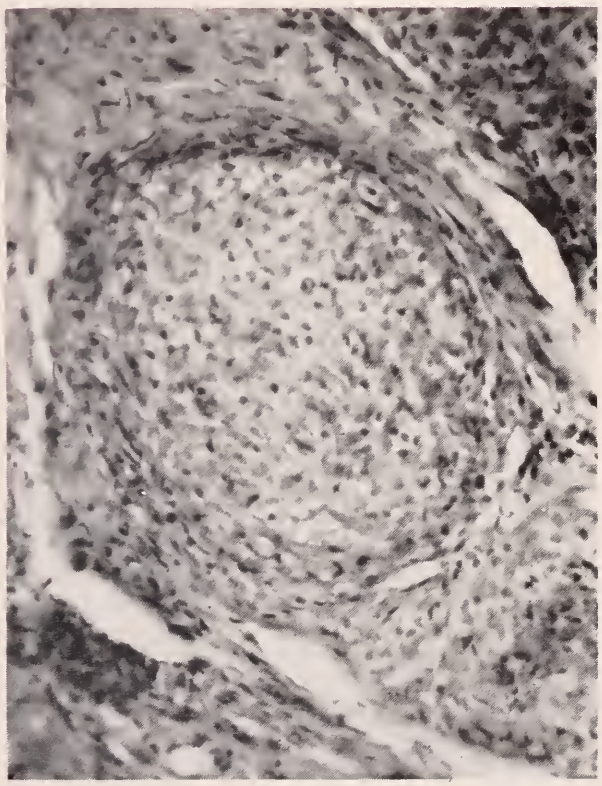


Fig. 5.—Microscopic picture showing tuberculoid structure resembling microscopic lesions of sarcoid. Swelling of endothelial cells of the blood vessels is evident.

tion of general practitioners, dermatologists, otorhinolaryngologists, pathologists and other specialists in the diagnosis of chronic tuberculosis-like or ulcerated lesions of the skin arising at the site of an abrasion sustained in or around a swimming pool.

Greenberg and Kupka,[18] of the California State Department of Public Health, reviewed the limited data available on this disease entity and concluded that the role of swimming pool construction and sanitation may be significant in controlling it. They noted that smooth surface walls and breakfront chlorination had proved effective in curtailing outbreaks. Linell and Norden[8] reported that when the pool associated with the epidemic they studied was rebuilt, the rough concrete walls replaced with smooth tiles, and the chlorination system made more effective, no new cases occurred. In commenting on Hellerström's suggestion that swimming pools be resurfaced with smooth tile, Rees and Bennett[12] remarked appropriately that if this measure does not deal with the causative agent in some specific way, it at least minimizes the possibility of producing abrasions. Other authors[19] also suggested the resurfacing of pools with smooth tile as the best means of dealing with the problem.

Summary

Recent medical literature, principally in the Scandinavian countries and America, directs attention to a new entity connected with abrasive accidents in swimming pools.

Four cases occurring in northern Florida are reported on the assumption that the granulomatous lesions which have been noted following swimming pool injuries in different parts of the world are, despite some variability in clinical characteristics, examples of the same disease.

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Discussion

DR. ALBERT G. LEWIS, Tampa: I certainly have enjoyed Dr. Farrington's excellent paper, "Swimming Pool Granuloma," but since I am neither a dermatologist nor a bacteriologist, my comments, of necessity, will be of a very general nature.

It has been known for many years that mycobacteria include a large number of organisms which are varied in their characteristics and that some are parasites and pathogenic for man or animal, whereas many strains are saprophytes and live in and upon man and animals and in soil and water.

Until recent years the finding of acid-fast bacilli in skin lesions, urine or sputum specimens was considered evidence of infection with human or bovine tubercle bacilli. If, however, these specimens were injected into guinea pigs with negative results, the organisms were considered harmless saprophytes.

We now know that all of the findings shown on the slide, a positive tuberculin skin test, acid-fast bacilli on smear, or even the granuloma with giant cells and caseation necrosis, are not sufficient evidence to prove infection with the human or bovine bacilli. Recently, too, those of us who treat tuberculosis have encountered a number of cases of chronic lung infection due to mycobacteria which mimic tuberculosis in producing a positive skin test and similar histologic and x-ray changes, but which are nonpathogenic for the guinea pig and which, as is the case with chronic skin ulcers due to Mycobacterium balnei, can only be distinguished by appropriate bacteriological methods.

In these cases animal pathogenicity for the guinea pig, or for that matter, any experimental animal, is not necessary to establish pathogenicity to humans.

Several investigators have shown that many different strains of mycobacteria are capable of causing a positive tuberculin reaction, and Palmer, of the United States Public Health Service, several years ago suggested that especially in the Southeastern United States the number of cases of active tuberculosis is too low for the high percentage of tuberculin sensitivity. He postulated at that time that other mycobacteria must be responsible which were as yet unrecognized.

Palmer and his associates also have shown that PPD prepared from 12 different mycobacteria can produce tuberculin sensitivity in the guinea pig, but that when a tuberculin is prepared from each strain of mycobacteria, the reaction to the homologous antigen is generally greater although cross reactions do occur. In instances, therefore, of chronic ulcerative skin disease as presented in this paper, a specific purified protein derivative prepared from the microorganism may be of potential diagnostic value.

Many investigators have noted the nonspecificity of the histology of tuberculosis since various mycobacteria and, in addition, fungi and other agents, may produce an identical pathological picture.

One may summarize by saying that only by detailed bacteriological study can one arrive at a diagnosis, although a history of abrasion and swimming may suggest the possibility of infection with Mycobacterium balnei.

The bacteriological study should include sensitivity studies since most such studies on recently identified mycobacteria reveal resistance to the drugs commonly used in the treatment of tuberculosis, such as isoniazid and PAS, as is the case with Myco. balnei. There, however, is usually a degree of susceptibility to streptomycin and other drugs prepared from the streptomyces suggesting that these drugs are the therapeutic antimicrobials of choice.

In closing, let me emphasize again the nonspecificity of the skin reaction, the histological response to infection, the finding of acid-fast bacilli on smear and the importance of detailed bacteriological studies together with the unimportance of proving pathogenicity for an experimental animal in order to establish pathogenicity in the human.

I am sure that there will be other cases of ulcerative skin lesions due to Myco. balnei recognized in Florida now that their presence is established and if chronic skin ulcers are subjected to bacteriological study routinely.

Again, let me thank Dr. Farrington for allowing me to discuss this very interesting and important paper.

Dr. Jack H. Bowen, Jacksonville: I have enjoyed this very interesting presentation of a rather uncommon, but definitely a clinical entity known as swimming pool granuloma.

I have had one such case which I would like to report and add to the four cases reported by Dr. Farrington. This patient was a 14 year old boy who gave a history of having a superficial abrasion on the right knee received when he fell on the sidewalk. The abrasion healed within four or five days as abrasions usually do, and without difficulty; however, in three or four weeks the patient noticed a nodule had developed at the previously healed site; the nodule persisted and eventually the lesion became ulcerated and drained a serosanguineous fluid when the crust was removed. The lesion had been present for about four or five weeks when I first saw the patient. On biopsy, the specimen was of tuberculoid structure; however, no acid-fast bacilli were demonstrated. A tuberculin skin test gave positive results. The lesion was surgically excised, and the patient was given streptomycin for a period of 10 days. Primary healing of the incision occurred, and there was no further difficulty.

I think there is a very striking similarity in all these cases where a superficial abrasion occurs, rapid healing follows and then a granuloma develops from three to five weeks later. This case differed from the four previously reported cases only in that the abrasion occurred on a public sidewalk instead of a swimming pool. There are several points to reiterate for they are important in pointing out the similarity and differences between swimming pool granuloma and tuberculosis verrucosa cutis of the extremities and lupus vulgaris on the face which it so closely resembles.

First, one sees a positive tuberculin skin test in both diseases for the causative organisms are at least antigenically similar. The skin test may give negative results before the infection and after the infection they may become positive; or, the infection may be superimposed in a person having a positive reaction to a tuberculin skin test.

Secondly, a point of similarity between the two conditions is that few organisms are demonstrated in the tissue and the histologic feature is one of tuberculoid structure.

Difference exists in that swimming pool granuloma is less likely to involve the regional lymph nodes than is tuberculosis verrucosa cutis. Also, culture characteristics of the etiological organisms differ.

Simple eradication of the lesion by excision or desiccation seems to serve well as a form of treatment. Lastly, the swimming pool granuloma has a much better prognosis than the inoculation type of tuberculosis.

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VOLUME XLVII
NUMBER 4

Ventricular Septal Defect

An Auscultatory and Phonocardiographic Study of Fifty Cases

LAMAR CREVASSE, M.D.
GAINESVILLE

Accurate diagnosis and clinical evaluation of congenital heart disease are today of great practical importance. The radiographic, electrocardiographic, and catheterization data have been emphasized to the point where diagnosis and absolute values are grossly overstated. The role of clinical diagnosis and evaluation by thoughtful auscultation is neglected. Ventricular septal defect is by far the most common congenital heart lesion and offers no real difficulties in clinical diagnosis. The purpose of this study was to correlate careful auscultation with phonocardiographic, angiocardiographic, electrocardiographic, and catherization data. The total auscultatory spectrum of ventricular septal defect was studied in 50 patients from the first few weeks of life through age 40. Phonocardiograms are shown primarily as graphic illustrations as they do not record sounds not heard by careful use of the stethoscope. Ventricular septal defect can be divided by clinical evaluation into the following groups as determined from these data:

Group I: Ventricular Septal Defect With Small Left to Right Shunt and Normal Pulmonary Artery Pressure

There were 24 patients studied in this group. They were essentially asymptomatic, and the defect was initially detected by the presence of a rasping, grade IV pansystolic murmur, maximal in the third and fourth left intercostal space, which is almost invariably accompanied by a thrill and sparsely transmitted to the apex. Over the pulmonic area is a decidedly separate blowing pulmonary systolic flow murmur (fig. 1a). The pulmonic second sound is normally split and of normal intensity (fig. 1b). The pulmonary artery pressure in this group was usually normal and always under 50 mm. Hg (table 1). The third heart sound at the apex representing rapid left ventricular filling is readily detectable and of moderate magnitude and duration. There was minimal or no cardiac enlargement, and the degree of left to right shunt at the ventricular level was minimal to moderate.

Group II: Ventricular Septal Defect With Large Left to Right Shunt and Moderate Pulmonary Hypertension

With larger defects and increased pulmonary blood flow, pulmonary artery pressure is elevated and closes the pulmonic valve earlier and with more vigor, producing accentuation and narrow splitting of the second heart sound. In this group (table 1) pulmonary artery pressure was elevated and ranged between 25 and 60 mm. Hg with the vast majority in the range of 40 to 60 mm. Hg. The third sound is prominent, and its duration and magnitude roughly parallel the degree of shunt. The systolic murmur remains essentially unchanged. There is usually combined ventricular hypertrophy by physical examination and the electrocardiogram. There is an appreciable left to right shunt.

Group III: Ventricular Septal Defect With Moderate to Large Left to Right Shunt and Severe Pulmonary Hypertension

There were 11 patients in this group. When pulmonary artery pressure exceeded 60 mm. Hg, the pulmonic second sound was markedly accentuated and single (table 1). The systolic murmur varied in intensity with the magnitude of the systolic pressure gradient between the left and right ventricle. As right ventricular pressure rises in response to pulmonary hypertension, the systolic murmur becomes of less intensity. The third heart sound again parallels the degree of shunt (fig. 2b). There may be solely right, left, or combined ventricular hypertrophy, depending on the degree of shunt and pulmonary hypertension.

Group IV: Ventricular Septal Defect With Balanced Shunt and Severe Pulmonary Hypertension (Eisenmenger's Physiology)

With very severe pulmonary hypertension, right ventricular systolic pressure becomes equal to or exceeds left ventricular and the shunt be-

Presently Florida Heart Research Investigator and Assistant Professor of Medicine, College of Medicine, University of Florida, Gainesville, Fla.

comes balanced, bidirectional or reversed. When right ventricular pressure equals or exceeds left, this obliterates the interventricular systolic pressure gradient and the systolic murmur may disappear, producing a "silent ventricular septal defect." The pulmonic second sound is now strikingly accentuated and single, and the murmur of pulmonic insufficiency may be present (fig. 2c). There is nearly always severe right ventricular hypertrophy. Atrial septal defect, "reversed" patent ductus, and primary pulmonary hypertension may, however, produce the same clinical picture in advanced stages.

Atrioventricularis Communis

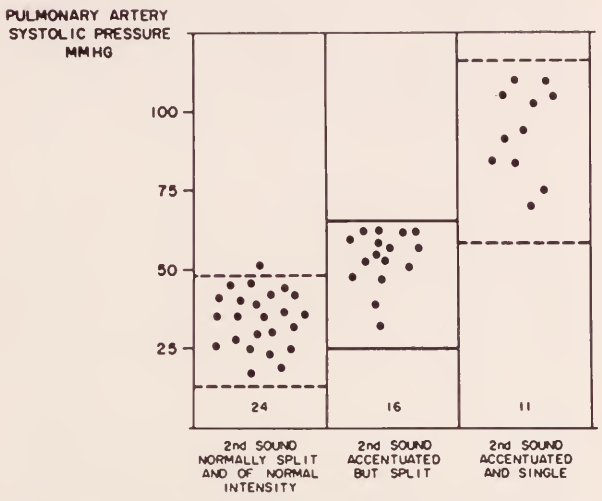
Three patients in this study had a combined atrioventricular communication. This differs in many respects from isolated ventricular septal defect. The murmur, unlike ventricular septal defect, is usually widely transmitted to the apex and may be maximal in this area (fig. 3). A congenital cleft deformity of the mitral valve is commonly associated with this defect and may produce the typical murmur of mitral regurgitation and or stenosis (fig. 4). Pulmonary hypertension is commonly present, producing accentuation of the pulmonic second sound in relation to the severity of the pulmonary hypertension. Left axis deviation and first degree atrioventricular block (fig. 5) are prominent electrocardiographic features.

Ventricular Septal Defect Simulating Pulmonic Stenosis and Patent Ductus Arteriosus

Occasionally in children, the murmur of ventricular septal defect may be diamond-shaped and maximal in the second left intercostal space, simulating pulmonic stenosis (fig. 5). The pulmonic second sound, however, is usually pathologically split in pulmonic stenosis. A pulmonary artery click and the late systolic murmur overriding the aortic component of second sound are characteristic. Diminution of pulmonary blood flow in contrast to increased pulmonary flow with ventricular septal defect is present.

Ventricular septal defect may mimic patent ductus arteriosus when loss of support of the aortic cusp by a high ventricular defect produces an associated aortic regurgitation. This creates a to and fro murmur closely simulating patent ductus, but can be differentiated phonocardiographically by the graphic relationships in that the bulk of the systolic murmur of patent ductus is

Table 1.—The distribution of relationships of closure of the aortic and pulmonic components of the second heart sound to pulmonary artery systolic pressure (see text).



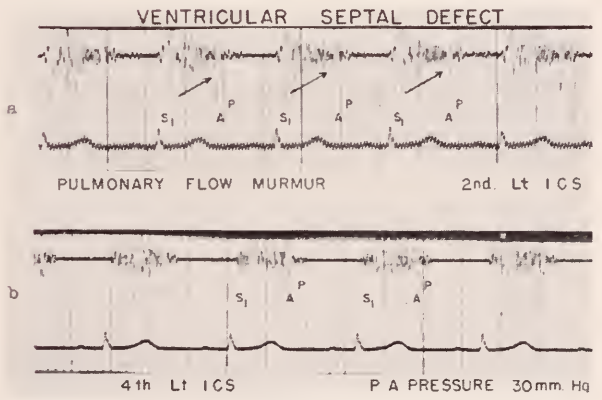


Fig. 1.—S_1=first sound. A, P = aortic and pulmonic components of second sound.

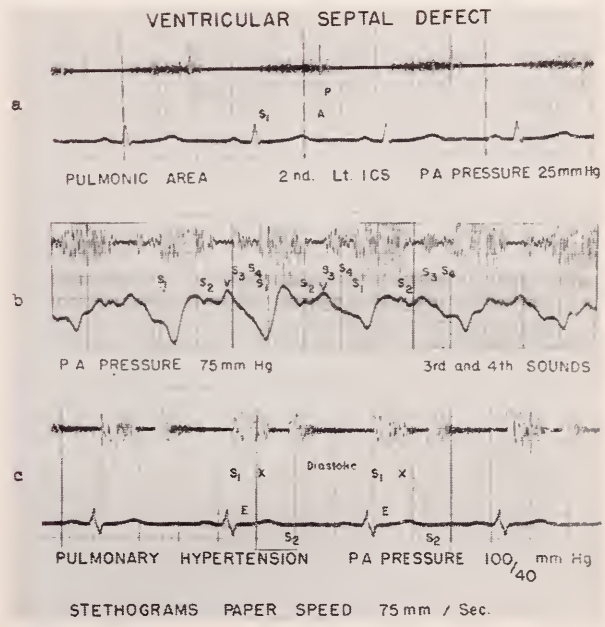


Fig. 2.—S_3, S_4= third and fourth heart sounds. X = contact sound. E = pulmonary artery ejection sound. S_2 = single second sound.

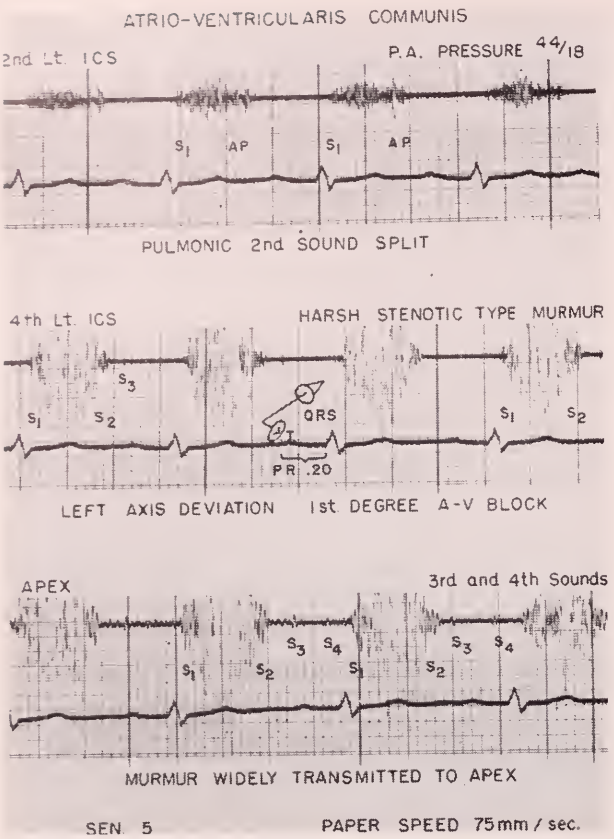


Fig. 3.—S_1=first sound. S_2=second sound. A, P= aortic and pulmonic components of second sound. S_3, S_4 = third and fourth heart sounds.

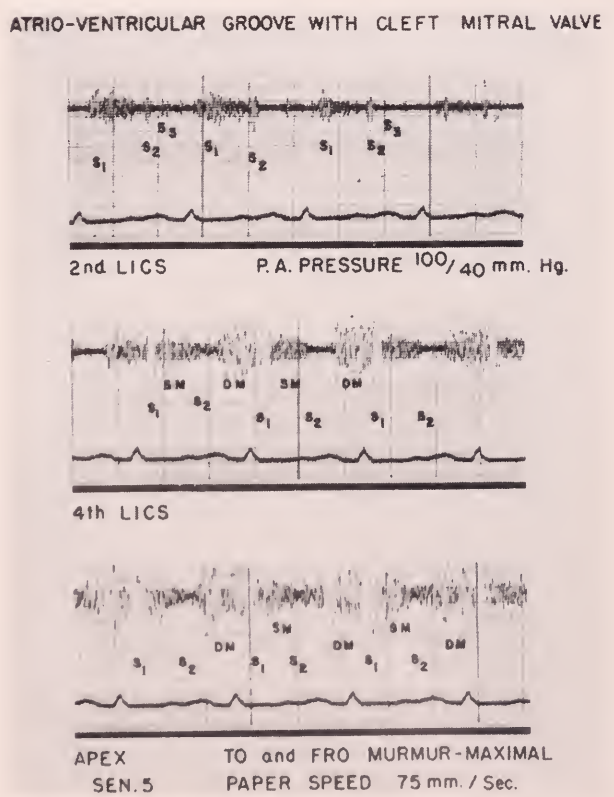


Fig. 4.—S_1, S_2=first and second sounds. S_3=third sound. SM = systolic murmur. DM = diastolic murmur.

delayed and will override the second sound completely. Likewise, when patent ductus is atypical and presents with a systolic murmur alone, it may be of considerable intensity and simulate ventricular septal defect. But again, it is late and grossly overrides the second sound.

Ventricular Septal Defect with Pulmonic Stenosis or "Acyanotic Tetralogy of Fallot"

Five patients, or 10 per cent of the entire group studied, had an associated infundibular and/or valvular pulmonic stenosis without cyanosis, a condition confused with isolated ventricular septal defect. Because of the obstruction to right ventricular outflow, however, the pulmonary artery pressure is low, and pulmonic valve closure is considerably delayed beyond 0.06 second, or may not be detected. Furthermore, the intensity

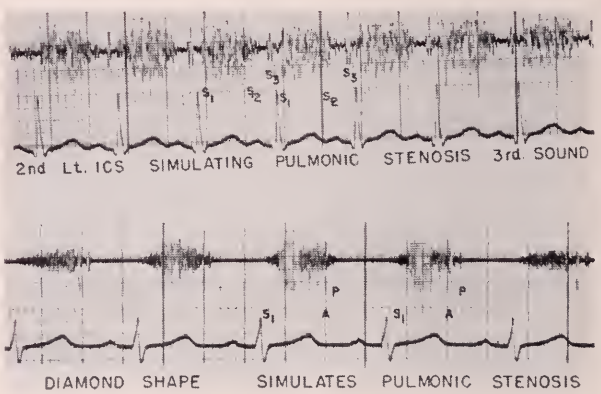


Fig. 5.—S_1, S_2 = first and second sounds. S_3 = third sound. A, P = aortic and pulmonary components of second sound.

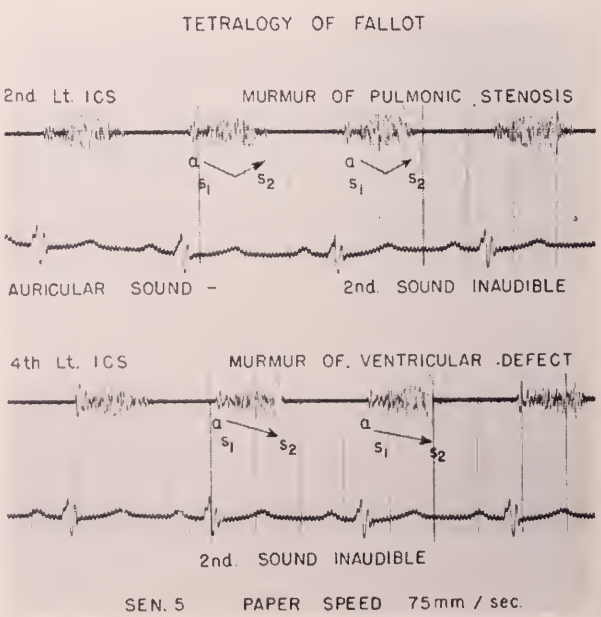


Fig. 6.—A = auricular sound or S_4. S_1, S_2 = first and second sounds.

of the systolic murmur is considerably less. By careful auscultation, the stenotic diamond-shaped murmur of associated pulmonic stenosis may occasionally be differentiated from the accompanying murmur of ventricular septal defect (fig. 6).

Summary

There are several points of value:

1. There are two murmurs with isolated ventricular defect. One is related to the defect per se and accounts for the rasping well localized systolic murmur in the third and fourth left intercostal space. The other distinct murmur in the second left intercostal space is related to increased flow across the pulmonic valve.

2. The status of pulmonary hypertension is of extreme clinical and prognostic importance. It can be reasonably assessed by the character of the pulmonic second sound. As long as pulmonary artery pressure is normal, the pulmonic second sound is normally split and of normal intensity. When pulmonary artery pressure is in the range of 40 to 60 mm. Hg, the pulmonic second sound is narrowly split and accentuated. When pulmonary artery pressure exceeds 60 mm. Hg, the pulmonic second sound is markedly accentuated and single. With severe degrees of pulmonary hypertension interventricular pressures may become equilibrated and the murmur of ventricular septal defect may disappear, producing Eisenmenger's physiology.

3. A third heart sound reflecting rapid ventricular filling is commonly present at the apex. Its magnitude and duration parallel the degree of the shunt.

4. Atrioventricularis communis can be suspected when the murmur of ventricular septal defect is maximal at the apex or the auscultatory findings of mitral regurgitation and/or stenosis are associated with it as a congenital cleft deformity of the mitral valve is usually present.

5. Ten per cent of patients suspected of having isolated ventricular septal defect will have an associated valvular and/or infundibular pulmonic stenosis without cyanosis. Careful auscultation will reveal the stenotic diamond-shaped murmur of associated pulmonic stenosis, and the pulmonic second sound is usually not detectable or considerably delayed.

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College of Medicine University of Florida.

The Last Word . . .

(Continued from page 379)

submitted such a plan for approval of the Federal Department of Health, Education and Welfare.

This would require no additional state appropriation by the state and provide 75 per cent relief to the counties in medical welfare costs to those 65 years of age and over, which are estimated to comprise over one-half of the needy sick of all ages now receiving medical care from the county and state. (One hundred per cent counties participation required to obtain federal matching funds.)

The issue of using federal matching funds in state programs for the needy sick was decided in 1935 with establishment of the Social Security law. The challenge now is to provide good comprehensive medical care for the needy sick under existing law and institutions motivated by Christian principles and for the preservation of human resources which will render this emotionally appealing issue useless to those who would use it as a vehicle to carry us on the socialist road to destruction.

A Preliminary Report of Cardiovascular Surgery Under the Florida Crippled Children's Program

WILLIAM R. STINGER, M.D.
TALLAHASSEE

In 1956, the Florida Crippled Children's Commission began to provide diagnostic services and treatment for children with operable heart conditions whose parents could not afford private care. Over 500 children with signs and/or symptoms of possible heart disease have been referred to Commission clinics since that time, and this paper describes the program and some of the results obtained.

Prior to 1956, intrathoracic and cardiovascular problems in infants and children were relatively unusual under the Commission program; so the Commission began by appointing a committee to investigate the special needs of these children. The committee, composed of recognized authorities representing appropriate professional disciplines, made recommendations which helped guide the Commission's efforts. These recommendations stressed the team approach to the problem, and it is interesting to note that similar recommendations were independently developed by the Subcommittee on Education and Standards of the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association.

Based on incidence and prevalence surveys in Escambia County and Dade County, it was also possible to make a rough projection of the case load. In 1956, it was estimated that there were approximately 6,000 persons in Florida with congenital heart disease, and at least a third of the cases would be operable. As indicated in table 1, this ratio proved fairly accurate. As far as the Commission was concerned, it was further estimated that about 150 cardiac referrals would be served each year, and approximately 50 would be deemed amenable to surgery. Subsequent experience has also confirmed these estimates within reasonable limits. Like most new activities, the Commission's cardiac program served relatively few children in the beginning, but there has been a steady increase in the number of referrals, and the Commission is now serving as many children as its funds permit.

The breakdown of conditions diagnosed and operations performed is shown in table 1. It may seem strange that the Commission observed many more ventricular septal defects than conditions such as patent ductus arteriosus. In considering these statistics, one must remember that this state agency limits its activities to the medically indigent, and diagnosis and repair of a defect

Table 1.—Types of Cardiovascular Conditions Diagnosed and Treated Under Florida Crippled Children's Program, 1956-1959

Cardiovascular Defect	Number of Patients	Number Operated on
Atrial septal defect	47	16
Aortic stenosis	16	4
Coarctation of aorta	15	5
Patent ductus	60	38
Pulmonary stenosis	37	23
Tetralogy of Fallot	62	26
Ventricular septal defect	163	20
Mitral stenosis	1	1
Lesion undetermined	105	0
	506	133

Table 2.—Results of Cardiovascular Surgery Under Florida Crippled Children's Commission Program, 1956-1959

Cardiovascular Defect	Greatly Improved	Improved	Unimproved	Deaths	Totals
Atrial septal defect	9	4	0	3	16
Aortic stenosis	0	3	0	1	4
Pulmonary stenosis	11	12	0	0	23
Patent ductus	23	12	1	2	38
Coarctation of aorta	3	2	0	0	5
Tetralogy of Fallot	8	10	2	6	26
Ventricular septal defect	7	10	0	3	20
Mitral stenosis	1	0	0	0	1
	62	53	3	15	133

such as a patent ductus is usually not as involved or expensive as diagnosis and surgery for conditions such as ventricular septal defects or tetralogies. It is highly probable, therefore, that most of these less complex conditions are examined and treated on a private basis and are not referred to the Commission. This preliminary screening also accounts for the relatively small number of patients with rheumatic heart disease or no heart disease.

As of October 1959, surgery had been performed on 133 of the 401 children with definite diagnoses of congenital heart disease and one patient with rheumatic heart disease. Twenty-six additional patients were scheduled for future surgery. As far as the remaining cases are concerned, most of these were either deemed inoperable by present surgical technics or represented minimal defects where surgery did not seem warranted. The parents of a few patients refused surgery, and several other patients were returned to the care of their private physicians with recommendations for surgery. The Commission has not attempted to follow the latter group.

Table 2 is based primarily on a subjective or symptomatic evaluation of the results of surgery. In some instances, the evaluation is also based on objective hemodynamic evidence including preoperative and postoperative catheterization reports. The Commission plans to obtain objective data on more of these patients over a greater period of time, and these results will be reported at another opportunity. Despite the inherent dangers of conclusions based on subjective information, the Commission is confident that the program is transforming most of these children, previously doomed to a short life of chronic invalidism, into virtually normal useful citizens.

P. O. Box 1508.

The Complete "D. & C."

Alvan G. Foraker, M.D.
JACKSONVILLE

Irregular bleeding may come from lesions high in the endocervical canal, inapparent on examination. These may include "in situ" or invasive squamous cell carcinoma. They may be present in patients whose cervices appear normal to inspection. Occasionally fragments of the tumor may be dislodged and included with corporeal endometrium in a standard dilatation and curettage. This happenstance may lead to the diagnosis of cervical carcinoma, even in the absence of a cervical biopsy. This is relying on a weak reed. Many cases of early cervical carcinoma must be missed in this fashion, to the patient's detriment.

When a patient is being subjected to dilatation and curettage of corporeal endometrium, cervical biopsy would involve only a slight increment in anesthesia time, surgical procedure and bleeding. The possible benefits are great, the deterring factors minimal.

From the Pathology Laboratory, Baptist Memorial Hospital, Jacksonville, Fla.

It is urged that cervical tissue be obtained for examination in every instance where corporeal curettage is undertaken for diagnosis or for treatment of irregular bleeding. Possible exceptions might include:

1. Cases with recent negative office biopsy. Office biopsies, however, rarely include endocervical curettage, and may not reveal concealed lesions in the endocervical canal.

2. Cases in which the slight increase in bleeding and in anesthesia time would be of critical importance.

3. Cases with recent negative cytological examination. Cytology is of utmost importance in detection and evaluation of uterine (including cervical) lesions. A positive or suspicious smear can lead to exact diagnosis (by tissue examination) and is of marked value. A negative smear has only cumulative value. It should not prevent further investigations in patients with clinically suspicious signs and symptoms. When smears are properly taken and processed, comparatively few

false negatives will occur in cervical neoplasms. The possibility, however, does exist. If a patient is to have dilatation and curettage of corporeal endometrium, cervical tissue should be examined also.

4. Cases of dysfunctional bleeding, as in infertility studies. One must, however, be sure that endocervical lesions play no part in the patient's disorder. How better can this be accomplished than by biopsy and endocervical curettage? The age group of cervical carcinoma overlaps that of clinically important infertility. Examination of cervical tissue can be of marked importance in these cases.

For optimum diagnostic value, the tissue specimens should be submitted separately as corporeal endometrium, endocervical curettings, and two or four quadrant squamocolumnar junction biopsies.

If examination of cervical tissue is made a part of "the complete D. & C." many patients will benefit.

Summary

As an important measure in the detection of early cervical carcinoma, it is urged that endocervical curettage and squamocolumnar junction biopsy be made a routine portion of dilatation and endometrial curettage, when done for diagnosis or for irregular bleeding.

800 Miami Road.

ABSTRACTS

Treatment of Meprobamate Intoxication with the Use of Methyl Phenidate: CASE REPORT. By David Potyk, M.D. South M. J. 52: 1148 (Sept.) 1959.

The purpose of this paper is to discuss the treatment of cardiovascular depression and collapse, with respiratory depression following an overdose of meprobamate in an elderly woman who attempted suicide. The use of methyl phenidate intravenously resulted in marked improvement with eventual recovery. It appears that this drug may be a useful antidote to meprobamate intoxication and by itself has had few side reactions.

Treatment of Acute Gout With Injection of Colchicine. By Lynn P. Carmichael, M.D. J. A. M. A. 170:1410-1411 (July 18) 1959.

While newer agents are valuable in the treatment of gouty arthritis, colchicine, one of the oldest and most specific pharmaceuticals available, remains the most useful drug in the treatment of this disorder in the opinion of this author. Cochicine injection is now available for intravenous administration. When the drug is given by this method in the indicated dosage, gastrointestinal side effects rarely occur and the response is more rapid than that obtained with the oral method. Four cases are reported which illustrate the diagnostic and therapeutic advantages of intravenously administered colchicine. It is concluded that the intravenous administration of this drug is a rapid, safe, and uncomplicated method of treating acute gouty arthritis. Also, it is of special value as a diagnostic procedure in those cases in which the diagnosis of gout is doubtful, because of its rapid action and the freedom from nausea, vomiting, and diarrhea often associated with oral administration.

A New Method for Identifying Blood of the Portal Circulation. By Winston K. Shorey, M.D., William H. Meyer, M.D., W. A. D. Anderson, M.D., Raymond E. Parks, M.D., and Norman M. Kenyon, M.D., South. M. J. 52:1052-1057 (Sept.) 1959.

This report deals with the methods employed in and the results of experiments pursued in the development of technics for differentiating blood in the portal circulation from blood in the systemic circulation. A concept for detecting the escape of blood from esophageal or gastric varices by introducing an identifiable material into the portal circulation and then finding a significant concentration of it in blood aspirated from the stomach is presented. Identifiable materials were introduced into the portal circulation of dogs by injection into the wall of the lower colon by means

of a modified sigmoidoscope. The injection of fluorescein resulted in portal vein concentrations of dye consistently higher than concentrations in the vena cava. Pathologic study revealed no significant damage to the bowel of dogs in which this technic was used. Radioactive iodine instilled into the lumen of the lower bowel was found to be absorbed just as effectively as that injected into the wall of the bowel. Human experiments demonstrated an increased absorption rate when it was instilled in an alcoholic solution as compared to instillation in physiologic saline. Further investigation is required to determine whether or not these observations can be applied to the practical problem of identifying hemorrhage from a ruptured esophageal or gastric varix. The authors note that the secretion of a high concentration of iodide by the gastric mucosa, as found by other investigators, probably precludes the use of iodine-131 for this purpose.

Correlation of Smoking Habits With Hemolytic Streptococci and Antistreptolysin O Responses. By Milton S. Saslaw, M.D., and Murray M. Streitfeld, Ph.D. Am. J. M. Sc. 237:754-758 (June) 1959.

Epidemiologic studies on β hemolytic streptococci conducted in Miami by the authors gave them an excellent opportunity to investigate any possible relationship of smoking habits of adults to the prevalence of streptococci in the human throat. Accordingly, data on smoking habits were collected at the same time that throats were swabbed for isolation of streptococci and venous blood samples were drawn for streptococcal antibody determinations. Analysis of findings from 1,812 throat swabbings showed that β streptococci were isolated from the throats of present smokers almost twice as often as from nonsmokers or past smokers, a highly significant difference statistically. Group A organisms also were isolated more frequently from smokers' throats, but the difference was not as great. Antistreptolysin O studies (1,611 samples) showed no appreciable differences in titers of serums from smokers when compared with those from nonsmokers. The authors concluded that the higher frequency of streptococcal isolation among smokers than nonsmokers and past smokers may be due to an effect of smoke products on streptococci or on the mucous membrane barrier of the host.

Wegener's Granulomatosis. Case Report: Antemortem Diagnosis and Observations on Effect of Treatment. By Ulfar Jonsson, M.D., and Dewitt C. Daughtry, M.D. Am. Pract. & Digest Treat. 10:47-52 (Jan.) 1959.

Wegener's granulomatosis consists pathologically of a necrotizinz granulomatous process of the respiratory tract, generalized vasculitis and focal glomerulitis. Clinically, it is a fatal disease entity characterized in the early stages by severe rhinitis and paranasal sinusitis often accompanied by pulmonary lesions simulating inflammation or malignancy; the later stages are characterized by a generalized arteritis and renal insufficiency. The diagnosis is seldom made during life. The authors describe in detail an instance of this disease diagnosed nine months antemortem. The presenting symptoms were rhinitis and sinusitis followed by multiple discrete nodules in the lungs. A considerable degree of symptomatic relief of nasal symptoms and clearing of pulmonary lesions followed steroid therapy. Death apparently was due to surgical complications and sepsis following a right lower lobe lobectomy. The literature is briefly reviewed, and the relationship between Wegener's syndrome and other similar clinical conditions is discussed.

Anesthesia for the Aged: A Comparative Evaluation. By Harry E. Danielson, M.D., and J. Gerard Converse, M.D. South M. J. 52:1132-1136 (Sept.) 1959.

A study on the relative safety of spinal versus general anesthesia in the aged patient undergoing an operation on the hip was undertaken with a view to throwing some light on one facet of the total picture of geriatric anesthesia. A group of 90 geriatric patients who had hip surgery was chosen at random for a comparison of operative and postoperative mortality and morbidity. Spinal anesthesia was used in 46 and general anesthesias in 44. The authors suggest that general anesthesia, utilizing the technic of analgesia plus relaxants, offers a more satisfactory method than the use of hypobaric spinal anesthesia.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

The Bright Side

All too often, and particularly when impending legislation points in a direction contrary to their desires, or a candidate for office holds views inimical to the best interests of medical practice, physicians are heard to lament the lack of leadership and political activity on the part of organized medicine as represented in the American Medical Association and the Florida Medical Association.

Legally, the limitations on political activity as outlined in various acts, namely, the Hatch Act, the Corrupt Practices Act, and the New Criminal Code, as relating to medical organizations are these:

1. The American Medical Association cannot legally contribute to or expend funds in support of, or in opposition to, candidates for federal office. (I presume the same law applies to labor unions.)

2. State and county medical societies, whether incorporated or not, are subject to the same limitations.

3. The law prohibits a medical society from: a. Endorsing a candidate, where it involves expenditure of general corporate funds. b. Contributing funds to any candidate for federal office. c. Using medical society letterheads or facilities to advance work in behalf of a candidate. d. Sponsoring any other form of advertising material for a candidate.

4. Individuals forming political committees must not make use of any official position or office which they may hold or occupy in any organization.

The Florida Medical Association and, it is hoped, its component societies lean over backward to stay well within the letter of the aforementioned rulings. On the positive side, medical societies, as organizations, can and should urge their members and others to register and vote.

There is a bright side, however, and it is unfortunate if not astounding that so many of our membership are unaware of an organization formed in 1950, independent of organized medicine, limited in membership to doctors of medicine and their spouses, and openly dedicated to engage in political activity. This group, the Florida Medical Committee for Better Government, arose out of the effective core of physicians and their wives who were instrumental in putting Senator George Smathers in office in 1950, defeating the incumbent, an outspoken advocate of socialized medicine and supporter of the Murray-Wagner-Dingell Bill. This Committee aided, in 1958, the return of Senator Spessard Holland to Washington against the candidacy of the same so-called liberal.

Within the state, even on the local level, this Committee has spoken out and supported candidates for various offices when it was in the best interest of the people to do so.

The objectives of the Florida Medical Committee for Better Government as noted in Article II of its By-Laws are: A. To uphold the tradition of individual liberty and the system of free enterprise. B. To constantly encourage and stimulate physicians toward better and more active citizenship. C. To stimulate and cooperate with similar committees of other groups whose purposes are in harmony with the aims of this body. D. To study the issues of government, records and platforms of candidates aspiring to state and national offices, and to make results of such studies publicly available. E. To cooperate with similar committees in other states.

In an election year, when good men are running for office as well as other men who are obviously opportunists, willing to stop at nothing to obtain votes, it is imperative that physicians, being educated, thoughtful, and far-seeing citizens, take an active part in politics. The Florida Medical Committee for Better Government gives you that opportunity to channel that activity where it can be most effective. Your dues, a pittance, are needed. Your support is even more desirable.

Leo M. Wachtel

THE JOURNAL
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More on the Art of Medicine

I do not love thee, Doctor Fell.
The reason why I cannot tell;
But this alone I know full well,
I do not love thee, Doctor Fell.

These words are thought-provoking today just as they were when written by Tom Brown, student at Christ Church, Oxford, nearly 300 years ago. Ofttimes one cannot express articulately the reason for his dislike or dislove of a person—a physician—but in the last analysis it frequently is the attitude of the disliked.

If a physician saves a life but does it in an impersonal, cold, ungracious manner, he is not apt to get much thanks. On the other hand, if a physician loses a patient by death, and his attitude has been one of solicitude, kindness and graciousness, members of the family are more apt than not to defend him and be grateful to him.

Two cases in point are that of an elderly, diabetic woman who lived through peptic ulcer perforation with peritonitis for 18 hours before she was seen professionally, and that of a middle-aged man who died unexpectedly while receiving antibiotics and general supportive care for lobar pneumonia. A review of the two cases gave rather convincing proof that the life of the first patient was saved by the professional skill of the doctor. Yet, the patient and the members of her family were not only unimpressed, but were even a little unhappy, for the doctor in charge had been gruff, had not taken time to explain the details of the case and had not made them understand what he was trying to accomplish. In the second case, however, the surviving members of the family could not seem to say enough by way of praise of the physician. He had been thoughtful and kind; he had explained the illness to those concerned and had given unsparingly of himself.

It might be remembered that most physicians in the horse and buggy era held the love, affection and deep respect of their patients even though they knew much less scientific medicine than we know today. They had much less they could say, but they knew when to talk and how to say it.

The medical profession has something to talk about, something to give and something to sell which is priceless, but frequently a problem arises —how much to charge?

Recently, in a talk before the Florida Society of Internal Medicine at its annual meeting in Jacksonville, a distinguished lay speaker com-

plained that he could not understand why he could not get a firm estimate of charges for professional services on health insurance policies prior to rendering of the services. It should hardly be necessary to remind our lay friend that services depend upon many intangibles that frequently cannot be foreseen. Not until a good history and thorough physical examination have been obtained can the physician predict how many laboratory, x-ray and other clinical studies will be needed and sometimes not then. Consequently, he frequently cannot foretell how much professional service will be appropriate to the individual case. In the interest of good public relations, perhaps members of the medical profession will want to agree upon a firm estimate for group health insurance policies with the hope that the total will average up satisfactorily.

A wise professor once advised one of the Editors that as much as possible he should deal with those people with whom he could establish rapport, and that he should make every effort to fill his practice with people whom he liked and who liked and appreciated him. He pointed out that it does not matter whether such are rich or poor, well-to-do or ordinary; funds will be forthcoming and fees will almost take care of themselves. On the other hand, there are people in all walks of life who cannot be pleased, who seem to look for faults and for someone to blame for their unhappy plight. An older lay friend, rich in knowledge of worldly affairs, put his advice more succinctly—if negatively: "You can't get anywhere dealing with sorry people."

If any phyiscian should doubt the importance of attitude in the office and at the bedside, let him try to picture a patient in real need of medical aid and advice, and then visualize what a difference may be made by the appearance of a physician with confidence and keen interest in the over-all medical problem at hand. Such a physician will want to charge for his services appropriate to the patient's station in life and his ability to pay. There will be no overcharge, for such services are quite priceless.

The Decline of American Medicine

The disintegration of American Medicine as it is now practiced may be expected to occur at an accelerated rate. Proof is everywhere, but no better evidenced than in the poor attendance and lack of accomplishment at most County Medical Society Meetings. Reasons for this disinterest are many, but cardinal among them are apathy, the division of physicians amongst themselves, implicit faith in the American Medical Association and its officers, and a general intransigence of thought on all paramedical problems.

Lucrative practices and the social prestige of the medical profession have removed the stimulus for change so necessary in an evolving social cosmos. The benign contentment of past accomplishment is merging into a paralyzing apathy toward any but professional problems. As medicine has become more complex and has borrowed increasingly from other scientific disciplines, divisions have occurred which are now pitting physician against physician whether it be the solo practitioner against a group, academists against practitioners, teaching institutions against organized medicine locally, and above all, supervisory councils, which physicians have developed, against physicians themselves. The various specialties whose only reason for existence is the attainment and application of wider knowledge are continually sniping at each other. Each specialty is more interested in protecting its own vested interest than in the preservation of medicine as a whole. Indeed, medicine is now a house divided.

Once the average American physician has become a Member of the American Medical Association, he believes that each and every one of his nonprofessional problems will be magically solved. One need only review the events of recent years to see how false this belief is and how insecure the position of the American physician has now become. A few years ago, Medicare appeared on the horizon. That it exists in its present state is no kudos for government or American Medicine. Recently, the Federal Employees Insurance Program has developed. The average

physician has no knowledge as to the functioning of this far-reaching legislation and how it will affect him. More recently, health insurance for the aged has been in the forefront. In each of these instances, the American Medical Association has run a scared race. In each, we have come off a second best. The reasons are simple. Every problem is given the same trite treatment and answer, namely: (1) Let's keep our own house clean, that is, admit to the public we are probably wrong, but we are going to improve. (2) Let the existing mechanisms take care of the problem, or why develop an "H" bomb when we have cannon balls. (3) Let us educate the public, or tell the people they really do not want social security and other benefits. (4) Have a five or eight point program of generalities which do not solve the problems—after all we are all against sin and that is enough.

It has been unfortunate that in recent years some of the leaders of American Medicine have been more concerned with their own aggrandizement than with the solution of the problems of organized medicine. The oratory of a recent American Medical Association president could not be surpassed, but it was ineffective. The fact that he challenged his adversaries to debates which never occurred did little to help our lot. At this time, we need no silver-tongued high school debaters, but thinkers! It is a sad commentary that medical politics is usually run by default. Practically anyone who is willing to attend meetings, support the status quo and never take a stand which will make members commit themselves on any issue is certain to get to the top. The American Medical Association on paper is a very democratic organization. In practice, however, the state delegates rarely change and rarely do they oppose or propose anything that has not been devised in the Chicago headquarters.

We can no longer afford officers to represent us in our own county societies or in Chicago who are apathetic or ineffectual. We need leaders who are willing to take a stand—a point of departure —whether they make enemies or not. It is time to stand and be counted.

Unless we as physicians begin to take an active part in our local organizations and elect delegates to do our bidding, we deserve the fate of our colleagues in other parts of the world. The problems which face American Medicine today are numerous and have been engendered by dynamic socioeconomic changes with which the physician alone cannot cope. First, we must face them. Then we must delineate and define them before we can solve them. Adequate care for the aged, indigent care, how best can the physician deal with a third party in medicine whether it be labor, industry, insurance carrier or government —these are merely facets of the multiple and as yet really unknown and undefined problems which beset us.

Thus it becomes the urgent duty of the American Medical Association in conjunction with its component societies to organize and conduct a study by a commission composed of the finest sociologists, economists, and political scientists that money and a virgin field for inquiry can entice. These select elite must meet with the heads of labor, industry, government and medicine in an attempt to find what the actual medical needs of the American public are and how best to meet them. We cannot enter into this study with a preconceived idea as to what our conclusion must be any more than an honest research worker begins a study attempting to prove a point. We must also discard the juvenile thought that American Medicine must exist in its present form such as it has for the past century or more and expect everything else in this land to conform to it.

Naturally, it will be prudent and atraumatic to solve our problems, if possible, within our present framework of medical practice. There is nothing radical nor socialistic with the foregoing realistic approach to the solution of our organizational and socioeconomic problems. The methods suggested are those we use daily in our every research center. Unless the American physician is willing to contribute a small amount of time, effort and money, the decline of American Medicine will rapidly enter the abyss of lay-controlled medicine. The best solution of our paramedical problems lies in bringing our capabilities into harmony with the evolving socioeconomic changes which no one controls but all help to mold. Let us use those methods to cure our illness which we use daily in the cure of disease. If American Medicine must change, and change it must to survive, let us be the ones to control the change for our good and for the good of our patients. Change in itself is of little value, but a guided change in attitude, approach and effort is the only means whereby we may stop the present rapid decline of American Medicine.

J. J. L.

Volume XLVII
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Some Notes and Cautions In Treatment of Stroke

Effective definitive treatment for cerebral infarction after cerebral thrombosis has occurred is not available. Moreover, we are unlikely to find agents or methods in the future which will do more than minimize the extent of brain destruction, and our therapeutic efforts in patients with completed stroke will continue to be directed toward return of maximal useful function in spite of continuing neurological defect. It is proper, therefore, to continue an aggressive search for preventive treatment and, in the same light, for those symptoms which warn of major catastrophe. The ultimate goal well may be a change in dietary habits of populations to prevent atherosclerotic disease, but this is of little immediate benefit to the patient in whom narrow hardened arteries have already developed. We will direct our attention, therefore, to the diagnosis and treatment of "stroke" *before it occurs* and ask if there are reasonably effective measures that may prevent this event.

Upon careful review, a large proportion (one half or more) of patients with cerebral infarction are found to have suffered from transient attacks of neurological dysfunction prior to their strokes. These transient focal ischemic attacks, often interpreted as "vasospasm," frequently may be related to reduced circulation in the distribution of major cerebral supplying vessels; the internal carotid and middle cerebral arteries on the one hand and the vertebral and basilar arteries on the other. Those symptoms formerly attributed to focal vascular spasm are more logically explained and demonstrated to be caused by atheromatous narrowing of major vessels, with blood flow passively dependent upon mean arterial pressure. These observations provided a first step of more than casual importance in preventive therapy. Many persons with vascular occlusive disease are found to have elevated blood pressure, and there is an understandable tendency for the physician to administer hypotensive drugs. Extreme caution is necessary. Hypertensive pressure levels may be required to force adequate blood for brain function through narrow vascular lumens. Reduction of blood pressure and flow may cause a major stroke, the very event we are trying to prevent. A first consideration is to maintain blood flow through narrow vessels and through tenuous collateral channels even by the use of pressor agents. Myocardial ischemia, paroxysmal abnormal rhythms and postural hypotension are among the more common events which may cause transient reduction in blood flow and result in episodic cerebral ischemia.

In recent years, much attention has been directed toward disease of proximal arteries in the genesis of stroke and of ischemic attacks. Many patients with these syndromes have been found to have narrowing or thrombosis of major vessels in the neck or even at the ostia at the aortic arch. Indeed, most patients with episodes of ischemia referred either to the carotid circulation or vertebral-basilar system are found to have large atheromatous plaques or complete occlusions in the major neck vessels. Attacks of hemiparesis, aphasia, or monocular blindness suggest disease in the carotid system. Attacks with such symptoms as diplopia, vertigo, alteration of consciousness, or bilateral visual phenomena suggest involvement in the posterior or vertebral-basilar circulation. Important diagnostic confirmation may be provided by the discovery of murmurs over the carotid bifurcation or the eyes with carotid atheromata, and over the subclavian arteries and behind the mastoids in vertebral artery narrowing. Retinal artery pressure may be significantly reduced ipsilateral to carotid occlusion and may be measured at bedside with a little practice. More conclusive diagnosis is made by arteriography in properly selected patients. Furthermore, by these methods, local atheromata in these vessels may be discovered at times in patients without (or before) symptoms. These plaques are often well localized, a fact which may be of considerable importance in treatment.

We have directed attention to one aspect of prevention, avoidance of blood pressure lower than the critical level for flow in narrowed vessels. Two additional approaches will be mentioned briefly; prolonged anticoagulation and surgical restoration of blood flow. Anticoagulant treatment has been found to be of little or no value in cases with completed stroke; indeed, it is probably

harmful and contraindicated. It may, however, be used with benefit in some patients with evolving strokes and in those with transient focal ischemic attacks. The initial enthusiasm for anticoagulants has now been tempered by time and experience. In random and controlled series of patients, proper prolonged anticoagulation does appear to reduce the frequency of focal attacks. There is, however, serious question as to the total effect. Not only may the anticoagulated patient have stroke, but the complication of serious or fatal hemorrhage is frequent enough to demand a high degree of caution. There is little doubt that devastating defect may be prevented or deferred in selected patients, but patients so treated must be carefully chosen.

Restoration of flow through a narrowed vessel to the brain by surgery has had increasing interest and attention. This is especially cogent because the narrowed segment or segments of artery may be restricted to vessels in the neck or thorax. Specific procedures include intimectomy or endarterectomy or bypass grafts and prostheses. It is too early to evaluate all of the results, but there is little doubt that flow can be restored through incompletely occluded arteries in many instances and that the patient may improve or stop having attacks. Few, if any, patients with total occlusions or completed strokes will benefit from surgery and the procedure should probably be reserved for those with transient attacks and incomplete atheromatous obstruction of flow. Both carotid and vertebral circulations should be visualized by x-ray arteriography prior to surgery. The former can be done in most instances by an experienced operator by percutaneous puncture of the common carotid artery in the neck. For the latter, retrograde filling from the subclavians may be required. In some, demonstration of the branches of the aortic arch may be necessary. Adequate visualization will frequently reveal disease at unexpected sites, thus altering the surgical approach or making it unwise. Surgery on vessels to the brain may be given serious consideration in patients who have symptoms related to atheromata in neck vessels, but probably should not be applied generally until long term effects have been evaluated. The procedure itself may precipitate stroke because of constriction of the vessel for performance of the surgery, embolization of atheromatous material, or institution of a propagated thrombus from the operative site.

Cerebral vascular disease will continue to be a serious problem, and its incidence will probably increase with an aging population. Continued investigations will undoubtedly bring more effective therapies and better methods of diagnosis *before the stroke*. Effective preventive treatment is available now for *some* patients; a number sufficiently great for the physician no longer to be satisfied with such incomplete diagnostic appellations as "little stroke" or "cerebral vasospasm." Each patient must be considered from these points: the extent and location of neural damage; the site or sites of vascular disease; the cause of the attack at the time it occurred and how recurrence may be prevented; finally, the treatment that is best for this patient, be it anticoagulants, surgery, or the simple withdrawal from hypotensive drugs.

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Eighth Annual Meeting Florida Diabetes Association Miami Beach, October 27-28, 1960

The Florida Diabetes Association will return to Miami Beach for its annual meeting late this month, and for the third successive year the Balmoral Hotel will be the headquarters. The dates are Thursday and Friday, October 27 and 28, and registration is scheduled for 9 a.m. on Thursday. Scientific sessions on Thursday morning and afternoon will be followed by a public meeting on Thursday night, sponsored by the Greater Miami Lay Diabetes Association. The scientific program will be continued on Friday morning and afternoon, with the annual business meeting scheduled for 1:30 p.m. on Friday.

Guest lecturers this year are Dr. Garfield G. Duncan, Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia; Dr. Alexander Marble, Physician, New England Deaconess Hospital, Assistant Clinical Professor of Medicine, Harvard Medical School, Boston; and Dr. Roger H. Unger, Assistant Professor of Internal Medicine, University of Texas Southwestern Medical School, Dallas. Member speakers on the program are Dr. A. Gorman Hills, Pro-

fessor of Medicine, Head of Division of Endocrinology, University of Miami School of Medicine, Miami; Dr. George F. Schmitt Jr., Assistant Clinical Professor of Pharmacology, University of Miami School of Medicine, Miami; and Dr. Joseph C. Shipp, Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville.

Serving as moderators for the four scientific assemblies are Dr. Grover C. Collins, President, Palatka, Dr. William C. Thomas Jr., Gainesville, Dr. James B. Tobias, St. Petersburg, and Dr. Morris B. Seltzer, President-Elect, Daytona Beach. The program is approved for postgraduate study, Category I, by the American Academy of General Practice.

The fee for nonmembers is $25 and for members $15. Requests for reservations may be sent to Dr. George F. Schmitt, Secretary-Treasurer, 30 S. E. Eighth St., Miami.

EIGHTH ANNUAL MEETING
FLORIDA DIABETES ASSOCIATION
BALMORAL HOTEL, MIAMI BEACH, OCTOBER 27-28

THURSDAY, OCTOBER 27 — MODERATOR: Dr. Grover C. Collins

9:00	Registration	
10:00	"Prevention and Treatment of Complications of Long Term Diabetes"	Dr. Marble
10:45	"Acute Complications of Diabetes"	Dr. Duncan
11:15	Coffee Break	
11:30	"Hormonal Status of Endogenous Glucagon and Its Role in Blood Glucose Homeostasis"	Dr. Unger
12:00	Questions	
12:30	Luncheon Meeting — Board of Governors	

MODERATOR: Dr. William C. Thomas Jr.

2:00	"Elevated Cholesterol in the Diabetic: Significance and Approach"	Dr. Shipp
2:40	"The Detection of Hyperparathyroidism"	Dr. Hills
3:15	Intermission	
3:30	"Management of Diabetic Coma"	Dr. Duncan
4:10	Questions	
6:00	Cocktail Party	
8:00	Public Meeting sponsored by Greater Miami Lay Diabetes Association	

FRIDAY, OCTOBER 28

MODERATOR: Dr. James B. Tobias

10:00	"Overinsulinization, the Most Common Error in Insulin Therapy"	Dr. Unger
10:45	"Differential Diagnosis and Treatment of Chronic Hypoglycemia"	Dr. Marble
11:15	Coffee Break	
11:30	"Long Term Treatment of Patients With Diabinese" (Resident paper)	Dr. Edith J. Bradley
11:50	Questions	
1:30	Business Meeting	

MODERATOR: Dr. Morris B. Seltzer

2:00	"Diabetes Acidosis"	Dr. Schmitt
2:20	Intermission	
2:40	Panel Discussion: "Oral Hypoglycemic Agents"	
	"Use of Agents Other Than Tolbutamide"	Dr. Unger
	"Place of Oral Agents in Management of Diabetes"	Dr. Marble
	"Perspectives in the Treatment of Diabetes Mellitus"	Dr. Duncan
3:50	Questions	

Florida Academy of General Practice Meets in Jacksonville October 20-22, 1960

The Eleventh Annual Scientific Assembly of the Florida Academy of General Practice will be held on Thursday, Friday and Saturday, October 20, 21 and 22, at the Hotel Robert Meyer in Jacksonville. All Florida physicians are invited to attend, and there is no registration fee. The course is accepted for 10 hours Category I credit.

The program will be presented by eminent speakers from throughout the nation. They include:

Mr. Mac F. Cahal, Executive Director, American Academy of General Practice, Kansas City; Dr. Paul E. Craig, Member, American Board of Abdominal Surgery, Tulsa; Dr. Emerson Day, New York City; Dr. Temple Fay, former Professor and Head of the Departments of Neurosurgery and Neurology at Temple University School of Medicine, President of the Philadelphia Neurosurgical Society, Philadelphia; Dr. James G. Lyerly, Jacksonville; Dr. Peter F. Regan, Professor and Head of the Department of Psychiatry, University of Florida College of Medicine, Gainesville; Dr. Joseph R. Shaeffer, Director of Medical Education, Santa Rosa Hospital, San Antonio; Dr. Philip Thorek, Chicago; Dr. Leon Unger, Associate Professor of Medicine, Northwestern University Medical School, Chicago; and Dr. T. A. Watters, New Orleans.

Dr. Raymond R. Killinger of Jacksonville is general chairman of the Assembly Committee and also chairman of the Program Committee. The officers of the Academy are: President, Dr. Elmer B. Campbell Sr., St. Petersburg; President-Elect, Dr. James T. Cook Jr., Marianna; Vice President, Dr. Willard E. Manry Jr., Lake Wales; and Secretary-Treasurer, Dr. A. Mackenzie Manson, Jacksonville.

The program follows:

THURSDAY, OCTOBER 20

6:00 p.m. Dinner Meeting of the Board of Directors and Committee Chairmen

FRIDAY, OCTOBER 21

8:00 a.m. Registration. Exhibit Hall opens

9:30 a.m. Invocation, introductions and announcements

9:45 a.m. "The Listless Patient Syndrome," Paul E. Craig, M.D.

10:45 a.m. "Allergy of the Respiratory Tract—Diagnosis," Leon Unger, M.D.

Noon Buffet lunch in the Meeting Room

1:30 p.m. "Let the People Behold You," Mr. Mac F. Cahal

2:00 p.m. "The Use of Psychopharmacological Agents," Peter F. Regan, M.D.

3:00 p.m. "Allergy of the Respiratory Tract—Treatment," Leon Unger, M.D.

4:00 p.m. "Strokes, Subdural Hematoma and Brain Tumor," James G. Lyerly, M.D.

5:00 p.m. Visit Exhibit Hall

7:00 p.m. Social Hour

8:00 p.m. Dinner Party

SATURDAY, OCTOBER 22

8:00 a.m. Registration. Exhibit Hall opens

8:15 a.m. "The Cancer Detection Examination," Emerson Day, M.D. (film)

9:00 "Disaster Medicine, An Integral Part of the National Effort," Joseph R. Shaeffer, M.D.

10:00 a.m. "Basic Concepts in Teaching Non-Psychiatric Physicians Management of Psychiatric Problems," T. A. Watters, M.D.

11:00 a.m. "Practical Considerations in Diagnostic Screening of Cerebral Accidents and Chronic Types of Paralysis," Temple Fay, M.D.

Noon Lunch

1:00 p.m. Visit Exhibit Hall

1:30 p.m. "If I Had An Ulcer," Philip Thorek, M.D. (film)

2:00 p.m. General Business Meeting, Florida Academy of General Practice

3:00 p.m. "Cerebral Hydrodynamics and Important Recent Clinical Tests for Establishing Diagnosis in Neuromuscular Disorders," Temple Fay, M.D.

4:00 p.m. "Application of Psychiatric Principles in General Practice," T. A. Watters, M.D.

Southern Medical Association Meeting St. Louis, October 31-November 3, 1960

More than 6,000 physicians and guests are expected to attend the Fifty-Fourth Annual Meeting of the Southern Medical Association, to be held in St. Louis. The convention opens on Monday, October 31, and runs through Thursday, November 3. The association last met in St. Louis in 1954. This meeting will be its sixth in this "Crossroads of the Nation," which is well known for its hospitality as well as for its central location.

All meetings will be held in the conveniently situated and admirably appointed Kiel Auditorium, which will also house the several hundred scientific and technical exhibits. The host society is the St. Louis Medical Society, and the general chairman of the local committee on arrangements is Dr. Grayson Carroll. The president of the association is Dr. Edwin Hugh Lawson of New Orleans. Florida's councilor is Dr. Joseph S. Stewart of Miami, and Dr. Sullivan G. Bedell of Jacksonville serves on the editorial board.

More than 300 scientific papers are scheduled for the 20 sections. These programs are of unusual excellence and comprise a total of 46 half-day sessions, covering every phase of medicine. They will be presented by guest speakers nationally known in their special fields. In addition, a special feature this year will be two "first time" symposiums. On Monday morning, October 31, a Symposium on Cerebrovascular Disease will be a noteworthy attraction, and on Thursday morning, November 3, a Symposium on Medical Economics will no doubt evoke wide interest. Distinguished authorities have been selected for these two programs which offer points of interest to all physicians.

The president's guest, Dr. Dale Alford of Little Rock, Ark., will speak at the president's luncheon on Tuesday, November 1. Dr. Alford won his seat in the Congress as a write-in candidate and is up for re-election. At the president's dinner on Wednesday, November 2, presentation will be made of the Seale Harris Award for outstanding work in the field of internal medicine and the association's Distinguished Service Award.

Southeastern States Cancer Seminar for Physicians Orlando, November 16-18, 1960

The Tenth Biennial Southeastern States Cancer Seminar for Physicians will be held at the Cherry Plaza Hotel in Orlando on November 16 to 18. Highlighting the theme "New Horizons of Cancer Research and Therapy," an outstanding faculty of nationally prominent speakers will present a variety of subjects. The Seminar is being sponsored by the Orange County Medical Society in cooperation with the Florida Medical Association and is supported jointly by the Florida State Board of Health and the American Cancer Society, Florida Division, Inc. There is no registration fee. The course carries credit approval of the American Academy of General Practice.

The distinguished lecturers and their subjects are: Dr. Oscar Auerbach, Senior Medical Investigator, Veterans Administration Hospital, East Orange, N. J., "The Relationship of Smoking to Changes in the Tracheobronchial Tree and Lung Cancer;" Dr. Alexander Brunschwig, Professor of Clinical Surgery, Cornell University Medical College, "The Problem of Recurrent Cancer of the Cervix and Corpus Uteri;" Dr. Oscar Creech Jr., Chief of Surgery, Tulane University School of Medicine, "The Perfusion Technic for Cancer;" Dr. George Crile Jr., Head of Department of General Surgery, Cleveland Clinic, "The Possible Role of the Regional Lymph Nodes in the Body's Defense Against Cancer;" Dr. Joshua Edwards, Professor of Pathology, University of Florida College of Medicine; Dr. James Grace, Roswell Park Memorial Institute, "Viruses in Cancer;" Dr. John R. Heller, President, Sloan Kettering Institute, "Advances in the Chemotherapy of Cancer;" Dr. Lyndon E. Lee, Coordinator, Research in Surgery, Chief, Extra-VA Research Division; Dr. George E. Moore, Director, Roswell Park Memorial Institute, "The Spread of Tumor Cells and Their Importance to Chemotherapy;" Dr. Antolin Raventos, Associate Professor of Radiology, University of Pennsylvania School of Medicine, "New Methods in Radiation Therapy for Cancer;" Dr. Philip Rezek, Professor of Pathology, University of Miami School of Medicine; Dr. D. A. Ross, Chief, Physics, Oak Ridge Institute of Nuclear Studies, "Whole Body Counting Methods and Instruments;" Col. Frank M. Townsend, U.S.A.F., M.C., Director, Armed Forces Institute of Pathology, "The AFIP: Its Activities and Its Role in the Cancer Program;" Dr. Jerome A. Urban, Assistant Attending Surgeon, Breast Service, Memorial Hospital for Cancer and Allied Diseases, "Recent Trends and Treatment of Breast Cancer;" and Dr. Vincent Vermooten, Clinical Associate Professor of Urology, University of Texas Southwestern Medical School, Dallas.

Members of the Orange County Medical Society serving on the committee on arrangements for the meeting are Dr. Cecil G. Butt, Chairman, and Drs. Courtlandt D. Berry, James R. Cook, Harold W. Johnston, and Harold R. Torrance, all of Orlando. Dr. L. L. Parks of Jacksonville represents the Florida State Board of Health on this committee. For advance reservations or further information contact the 1960 Cancer Seminar Committee, 17 Lake Street, Orlando.

PHYSICIAN'S HOBBIES

Florida Physician-Artists Win Awards

The American Physicians Art Association held its Twenty-Third Annual Art Exhibit at the Miami Beach Auditorium and Exhibition Hall during the American Medical Association convention there June 13 to June 18, 1960. Florida was well represented with 49 entries from 20 physician-artists throughout the state. Out of 71 awards presented, Florida entries won 26 prizes in the various divisions which included Painting, Sculpture, Crafts and Photography, with Painting subdivided into Oil Scenic, Oil Still Life, Water Color, Portrait, Graphics and Abstract, and Photography subdivided into Color and Black and White. All categories were also divided into Beginner and Advanced Classes.

The 26 Florida awards consisted of four first prizes, five second prizes and three third prizes. The remainder were merit awards.

Dr. Ferdie Pacheco of Miami won a first prize for a Graphic in the Beginners Class entitled "Old Jazzman." Dr. I. Leo Fishbein of Miami Beach won a first prize for an Oil Scenic in the Beginners Class entitled "The Parthenon." Dr. Ben-Henry Rose of Miami Beach won a first prize for a Portrait in the Beginners Class entitled "Chinese Beggar," and Dr. Frank E. Bowser of Key West won a first prize for a Water Color, Advanced Class, entitled "Pennsylvania Farm in Spring."

Second prize winners included Drs. Wilfred Lansman and Jacob A. Glassman of Miami Beach, Ferdie Pacheco of Miami, Louis Lemberg of Coral Gables and Frank E. Bowser of Key West.

Third prize winners included Drs. David S. Howell and Ferdie Pacheco of Miami and Frank E. Bowser of Key West.

Honorable mentions went to Drs. Lawrence R. Medoff and Wilfred Lansman of Miami Beach and William Shedden of Ormond Beach.

All prizes were for paintings. Only three entries were made in the Craft category, but these did not win awards. There were no entries in the Sculpture or Photography divisions.

We are hoping for an even greater turnout from Florida for the Twenty-Fourth Annual Art Exhibit which will be in New York next June—more entries and more awards, particularly in Crafts, Sculpture and Photography. We are planning an art show for the Florida Medical Association convention in Miami Beach next May and expect to send it up to the American Physicians Art Association Exhibit in June. All those interested in exhibiting at the Florida Medical Association convention and/or the American Physicians Art Association Exhibit, in becoming a member of the American Physicians Art Association or in forming a Florida Physicians Art Association should contact me now at 1680 Meridian Avenue, Miami Beach.

Wilfred Lansman, M.D.
South Atlantic Regional Director
American Physicians Art Association

SHARE YOUR HOBBY

My hobby is _____

_____

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Please reserve space for me to display it at the Annual Meeting in Miami Beach.

Signed_____

Mail to:
Thad Moseley, M.D., Chairman
Committee on Scientific Work
P. O. Box 2411, Jacksonville

OTHERS ARE SAYING

Democracy Is Not a Spectator Sport!

The Constitution of the United States says nothing about political parties. The Founding Fathers, in fact, looked upon parties as an evil, but a necessary evil. Yet political parties have become as vital to the proper functioning of democratic government as have the legislatures, the executive, and the courts.

The men who built this republic were proud to be politicians, because they were rugged individualists who had come to the new world to worship God in their own fashion and to run their own affairs. In their town meetings every man had his day and most spoke their mind boldly.

In Greece, the name for a town was "polis." Those who ran the town, its citizens, were "politikos." Our forefathers knew this and knew they had to be politikos, or politicians, to keep their freedom. They instituted government to secure our inalienable rights to life, liberty, and the pursuit of happiness. Government derived its power only from their consent. They proudly gave their time for it, for they wished to govern themselves.

We still have self-government and it still works, but it must have the *active* support of all the citizens. Over the years our country has grown and prospered and life is becoming more and more complex. People are no longer able to attend to all their needs themselves. Therefore we have to specialize. Our professional politicians are specialists too—specialists in making the laws or in administering them. The rest of the people are largely content with voting for or against them, and only about 60 per cent do that much.

In 1958 a total of 104,600,000 Americans were of voting age, but only 44,550,000 of them went to the polls to select their senators, congressmen, governors, state legislators, and so on. The senators and congressmen, governors, and others are the men and women who have been taxing us, spending our money, regulating us, telling us—in many cases—how we can run our businesses, resolving our place in the world. But a good deal less than half of us seem to care.

In 1956 some 102,000,000 Americans were old enough to vote, but only a little more than 62,000,000 were counted in the presidential contest, while 59,000,000 were all that cared about who made up the House of Representatives, and only 44,000,000 expressed themselves on the Senate.

An active, intelligent interest in government is an inherent part of good citizenship. After all, we were citizens before we received our degrees in medicine, and even after retiring from practice we will continue to be citizens and must play our role with vigor and courage.

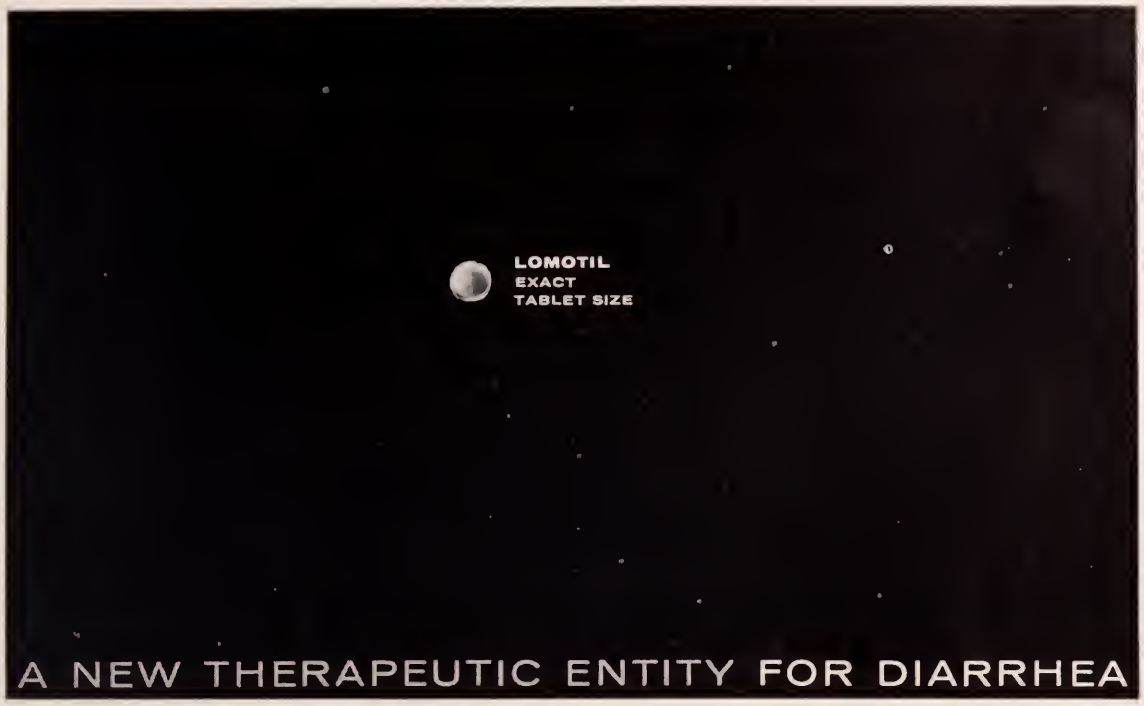
The first political obligation of each physician and his family is to register and vote in the party of his choice. Before he does register and vote, the physician should play an active role in the functioning of a party. As long as our country has a two-party system the candidates will be chosen and the platforms determined by those who participate actively in political affairs.

Most people confuse politics with issues. They do not know or they forget the "mechanics of politics," the mechanics of selecting, nominating, and electing citizens to public office. It means that politics and government should be in the mainstream of every adult's life. They are America. Freedom is something that is maybe the most glorious of all things. The entire complexion of life, liberty, and the pursuit of happiness changes abruptly when freedom passes by. Think of Hungary and some other countries. Think of many places where freedom does not exist.

History has demonstrated that governments begin to disintegrate when the people tend to depend on the "State" for everything. Paternalism is just as fatal as dictatorial power.

You, as an American, have an obligation to protect the independence and freedom which our forefathers gave to us. Nowhere else on earth at that time did people know the joys of being proud and free. It was considered the American experiment. News of it spread like lightning from shore to shore. This experiment is not dead. It has proved itself through years of stress and years of brilliance, from the town meeting to the halls of Congress. But are we as free today and will we be as free tomorrow?

The best way to preserve this freedom is to have millions of Americans taking an active part in government through politics. Responsible people from all walks of life should and must take an interest. Remember that our government can be no better than the men you elect. More and more of our citizens must get to know the candidates, know the issues, and take an active part in politics. Good government and freedom are



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

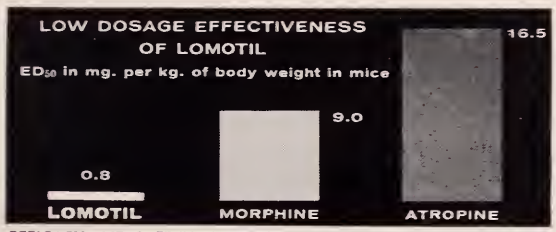
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately $\frac{1}{11}$ the dosage of morphine and $\frac{1}{20}$ the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control . . . with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about $\frac{1}{11}$ the dosage of morphine hydrochloride and in about $\frac{1}{20}$ the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. ($\frac{1}{2400}$ gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

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P.O. Box 5110, Chicago 80, Illinois

Research in the Service of Medicine

your responsibilities. If any group neglects to participate actively in the election of political leaders and the formation of political decisions, to that extent the democratic processes fail to function as intended by the authors of our Constitution.

The time has come for us to plunge into the cold waters of reality and to take an active part in political campaigns. What we are going to be able to do as medical men will depend upon *what* we are doing as *citizens*.

Learn the value of one vote—YOUR OWN. Democracy is not a spectator sport!

J. F. R.

Reprinted from The New York State Journal of Medicine 60:2673-2674 (Sept. 1) 1960.

100 STOCKS *for the* PRICE OF ONE

Now you can own mutual fund shares and have an interest in many investment opportunities, chosen and watched by professional managers who make changes when considered advisable. For free information and our suggestions, check your aim and mail the coupon below.

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BUSINESS ESTABLISHED 1865
MEANS 95 YEARS OF EXPERIENCE!
MEMBER NEW YORK STOCK EXCHANGE
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☐ Current Income
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I understand that information is for guidance only —and does not assure achievement of objective.

BLUE SHIELD

Advertising Carries the Message

PURPOSE.—Why have a Blue Shield? This has been asked—is continuing to be asked—by many persons, including some doctors. The answer, not lending itself readily to abbreviated explanation, can best be summed up by saying that so far it is the best method of prepayment yet devised against the expenses of illness, because it provides a professionally sponsored and supervised, voluntary plan with the greatest amount of coverage for the most people in all walks of life at the lowest cost. Included in this preferred protection are a high proportion of poor risks, with more than a fair share of the aged; made available through group coverage, conversion privileges without regard for age or health condition, and nongroup contract availability with no restrictions on age. Such practically unlimited coverage, from an underwriting standpoint, will continue to be available only if Blue Shield is strong.

STRENGTH.—In union there is strength. Trite truism of the times, it has never been more apropos than when applied to the partnership of the medical profession and Blue Shield. The strength of Blue Shield is that of the medical profession. Equally, the profession's position in opposition to the social planners has been strong and forceful because it has been able to point to Blue Shield as proof of the workability of the voluntary method. To remain strong and to utilize their strength to advantage, doctors must influence the thinking in their communities.



NEOCHOLAN®

Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

PITMAN-MOORE COMPANY
DIVISION OF ALLIED LABORATORIES, INC.
INDIANAPOLIS, INDIANA

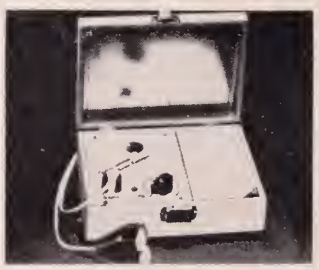
INFLUENCE.—The people of any community naturally look to their doctors for guidance in medical care and related fields. Each citizen is understandably concerned that some provision has been made to give him and his family protection against the unpredictable expenses of illness. Because of his high regard for his physician he also wants to make certain that his doctor is going to get paid when his services are required. Letting patients know that Blue Shield is the one program of prepayment approved and guided by their doctor will benefit patients, community and profession alike. Unequivocal support of the doctors' plan makes not only for strength, but progress in assuring perpetuation of voluntary methods.

PROGRESS.—It is with pardonable pride that physicians point to the remarkable advances in medical science in recent years. Progress in type and extent of prepayment protection has also been notable. When Americans want something, they usually find a way to get it. When their old problems remain unsolved by existing methods, then they seek new ways to cope with them. Whether the medical profession is happy with the situation is academic. Prepayment medical care is here to stay. Only through Blue Shield can there be assurance that it is properly guided and adequately controlled. Progress in prepayment will continue in the desired direction only if, as in medical care, the quality of service never becomes secondary.

QUALITY.—Just as there is no substitute for the doctor of medicine, there is no second best prepayment program for medical care. Aggressive support by the medical profession of the Plan which it originated, and over which it has control, convinces the public that doctors are capable of directing Blue Shield, and are thus less inclined to listen to suggestions that government can do better. Conversely, active support signified that plans without doctor guidance and control are inferior in the quality of protection provided.

During the last six months your Blue Shield has endeavored, through the advertising pages of this Journal, to remind Florida physicians that purpose, strength, influence, progress and quality are basic and indispensable to a prepayment plan acceptable equally to the public and to the medical profession. Following a principle of modern advertising technic you will find the number one advertisement, "Purpose," repeated on page 391

COMBINED
MEDICAL-ELECTRONIC
RESEARCH UNITS


Activator Model Y-4


U. S. Model 108

Now ready for market following thorough clinical testing. For rehabilitation of face and small muscle groups, post surgical, accidents, palsies and metabolic changes with age, proven value of the newly developed Model Y-4 has been established. Likewise, the supreme value of Ultrasonic energy as a decongestant (well known) in painful and inflammatory conditions of facial and sinus areas, can now be accomplished by the specially designed U.S. Model 108. Both portable for physicians' office or can be carried in his bag. Both represent a new contribution to all branches of medicine and surgery. Manufactured by renowned Zeigler Electronics Company.

MEDICAL PRODUCTS COMPANY, INC.,
Distributors for Florida
P. O. Box 34-27 Coral Gables, Florida

"Sometimes, I almost wish I were human so I could clear up this close-up, clogged-up nose of mine with TRIAMINIC®."

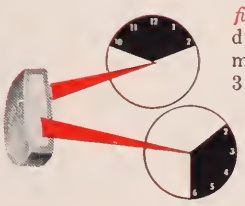


...and for humans with CLOGGED-UP NOSES...

Nasal congestion often persists with "bulldog tenacity." Nose drops and sprays often reach only the more superficial respiratory membranes and therefore fail to provide adequate relief. Furthermore, they may add to the patient's misery by producing rebound congestion, ciliary inhibition, and eventually "nose drop addiction." TRIAMINIC reaches *all* nasal and paranasal membranes *systemically* – provides more complete, longer-lasting relief while it avoids the harmful side effects associated with topical medication.

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then – the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

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BAMADEX

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

of this issue. It is significant that the plant world, which epitomizes all these fundamental characteristics is being used to supplement pictorially the general theme running through the messages.

STATE NEWS ITEMS

Dr. Hyman Sporn of Hollywood has returned from an extended trip abroad where he participated in two surgical conferences. From June 27 to July 7, Dr. Sporn was in Bordeaux, France, attending an otological functional microsurgery postgraduate course conducted by Dr. M. Portmann. From July 8 to July 31, he was in Vienna, Austria, where the conference on plastic surgery and microsurgery of the ear was conducted.

Dr. James N. Patterson of Tampa attended the meeting of the American Association of Blood Banks held in San Francisco on August 21-26.

Dr. Robert E. Zellner of Orlando was principal speaker at a recent meeting of the Orange County Pharmaceutical Association held in Orlando.

The Florida Society of Pathologists will meet in Sarasota on October 15-16, according to announcement by Dr. John A. Shively of Bradenton, secretary. Meeting jointly with the Society will be the Florida Division of the American Society of Medical Technologists. The societies will meet for the scientific session and dinner on the evening of October 15, but each will have separate business meetings.

A course for physicians in the latest developments in care, management and theory of the problems of prematurity has been scheduled for December 15-16 at Jackson Memorial Hospital, Miami. Credit will be allowed by the American Academy of General Practice. Apply to Bureau of Maternal and Child Health, Florida State Board of Health, P. O. Box 210, Jacksonville.

The annual meeting of the Southern Thoracic Surgical Association will be held November 17-20 in the British Colonial Hotel, Nassau, Bahamas. Information about the meeting may be obtained from Dr. Hawley H. Seiler of Tampa, who is secretary of the Association.

(Continued on page 436)

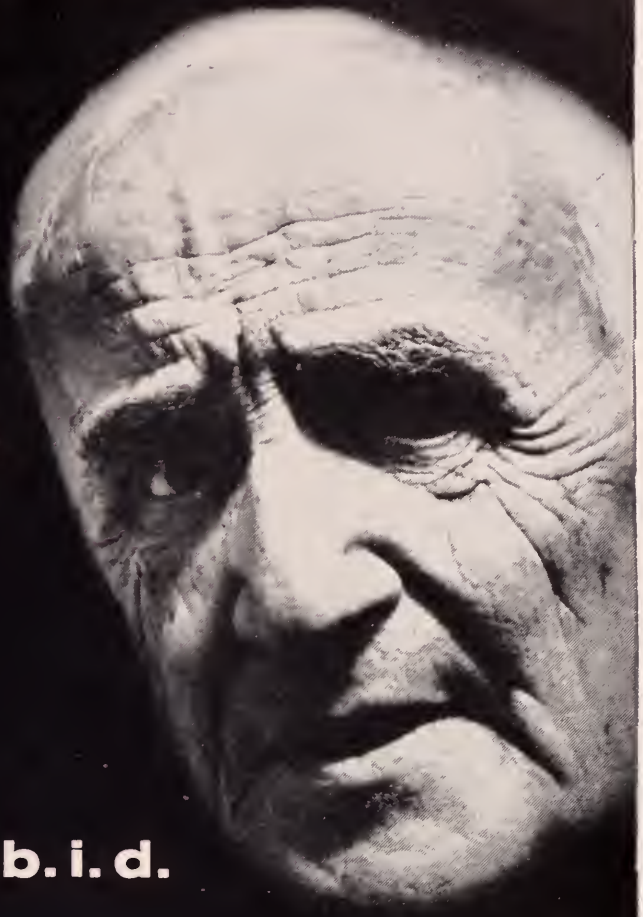
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Geroniazol TT* b.i.d.



- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio



attains
sustains
retains

extra
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activity

DEC

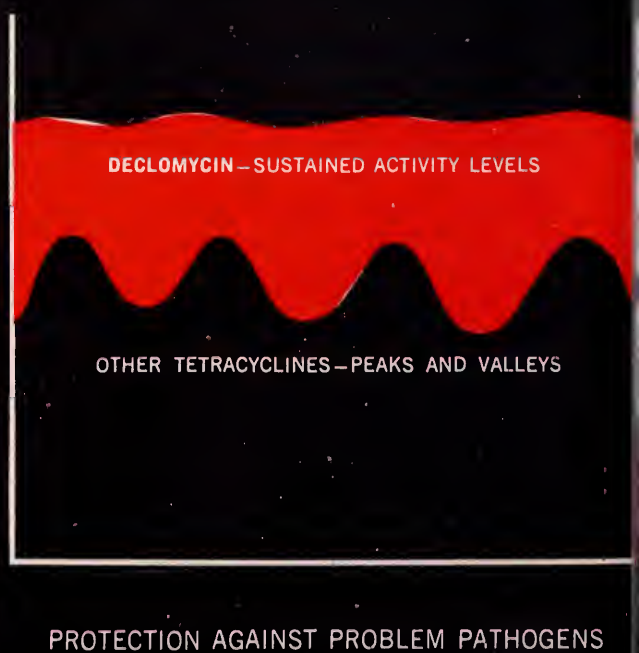
attains activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustai through the entire therapeutic course, the high act ity levels needed to control the primary infection a to check secondary infection at the original—or another—site. This combined action is usually s tained without the pronounced hour-to-hour, dose dose, peak-and-valley fluctuations which char terize other tetracyclines.



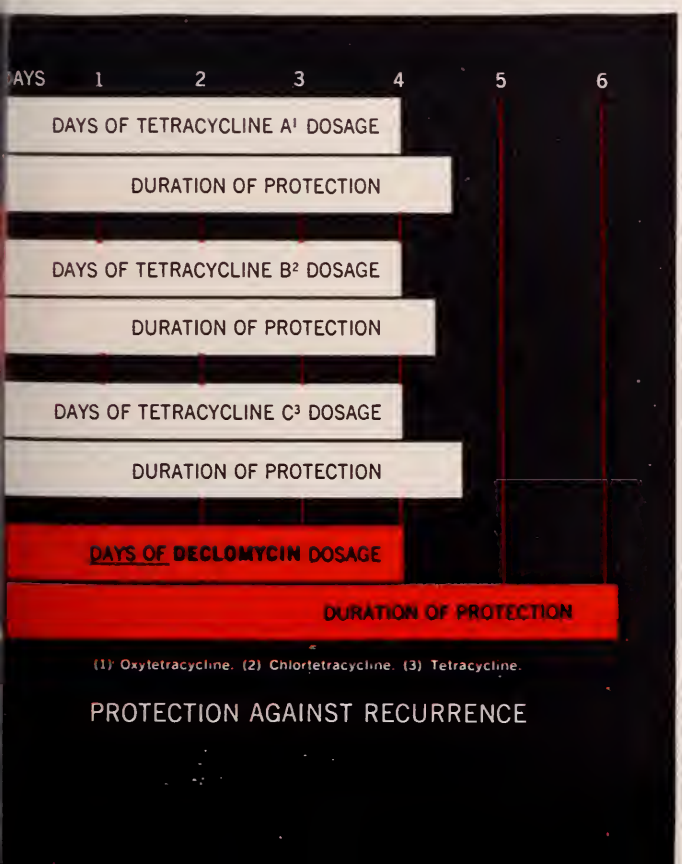


LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York

(Continued from page 432)

Dr. Joseph G. Seltzer of Orlando returned on September 20 from attending the Sixth International Congress of Internal Medicine held in Europe.

The Southeastern Allergy Association will hold its annual meeting on October 21-22 at the Atlanta Biltmore Hotel in Atlanta, Ga., according to announcement by Dr. Katharine B. MacInnis of Columbia, S. C., secretary-treasurer. Dr. Susan B. Dees, Duke Hospital, Durham, N. C., is in charge of the program.

The Twenty-Fifth Annual Convention of the American College of Gastroenterology will be held at the Bellevue-Stratford Hotel in Philadelphia on October 24-26. The program will consist of individual papers, a clinical pathological conference and motion picture films.

Dr. Louis L. Amato of Fort Lauderdale is among the 32 delegates designated by Governor LeRoy Collins for appointment to the White House Conference on Aging to be held in Washington January 9-12.

Dr. George W. Morse of Pensacola was guest speaker at a banquet held there recently which honored graduates of the School of Nursing of the Sacred Heart Hospital.

Drs. Francisco A. Hernandez and Milton S. Saslaw of Miami participated in the program of the Sixth Inter-American Congress of Cardiology held August 14-20 at Rio de Janiero. Dr. Hernandez took part in a panel on "Diagnosis of Congenital Heart Disease," and Dr. Saslaw presented a paper entitled "Prevention of Primary Attacks of Rheumatic Fever: Field Trial."

Dr. Richard M. Fleming of Miami presented an address on "Surgery and Surgeons for a Growing America" at a recent meeting of the Rotary Club of Miami Beach.

Dr. Spencer C. Manrodt of Melbourne was guest speaker at a recent meeting of District 31, Florida Nurses Association, held at Melbourne.

The Southeastern Region of the College of American Pathologists and the Virginia Society of Pathologists will hold a joint meeting at the John

adult stable diabetics and a significant number of sulfonylurea failures respond to

DBI

trademark, brand of Phenformin HCl

adult stable diabetes

"In our experience the action of DBI on the adult stable type of diabetes is impressive . . . **88% were well controlled by DBI.**"[1]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI], and such control was occasionally superior to that of insulin. This was true regardless of age, duration of diabetes, or response to tolbutamide."[2]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

sulfonylurea failures

Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

"DBI is capable of restoring control in a considerable portion of patients in whom sulfonylurea compounds have failed, either primarily or secondarily."[5]

"All twelve secondary tolbutamide failures have done well on DBI."[6]

"34 out of 59 sulfonylurea primary failures were successfully treated with DBI."[7]



Marshall Hotel in Richmond on November 25-26 on kidney disease.

The Department of Ophthalmology of the Emory University School of Medicine will sponsor a postgraduate course in ophthalmic surgery on December 1-2 in the auditorium of the Grady Memorial Hospital in Atlanta. Diagnostic principles and techniques, preoperative and postoperative management, and surgical principles and techniques in extraocular muscle surgery, cataract surgery and glaucoma surgery will be discussed by a distinguished faculty.

The Fall meeting of the Florida Orthopedic Society will be held at the Boca Raton Club, Boca Raton, on Saturday and Sunday, October 15-16. Members of the Society who are planning to attend should make arrangements directly with Mr. I. N. Parrish, Boca Raton Hotel and Club, Boca Raton, Fla.

An interim meeting of the Florida Urological Society has been scheduled for the weekend beginning Saturday, October 8, at Paradise Point, Crystal River, according to announcement by Dr. Henry C. Hardin Jr. of Miami, secretary-treasurer.

The Fall Meeting of the Florida Psychiatric Society is being held at Clearwater on October 15-16.

Dr. Joseph G. Matthews of Orlando was guest speaker at a recent meeting of the Lake County Medical Society held at Clermont. His subject was the complications of femoral fractures in children.

Dr. L. Roland Young of Daytona Beach was principal speaker at a recent meeting of the Daytona Junior Chamber of Commerce. The title of Dr. Young's address was "Fundamentals in Prevention of Nervous and Mental Diseases."

Dr. Henry F. Keiber of Winter Haven attended the meeting of the International College of Chest Physicians held in Vienna, Austria, August 28-September 2.



DBI

lowers blood sugar in mild, moderate and severe diabetes, in children and adults

not a sulfonylurea... DBI

(N^1-β-phenethylbiguanide) is available as white, scored tablets of 25 mg. each, bottles of 100.

Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corp.

Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 401 applicants who took the examination of the Board, held June 20-21, 1960, in Miami Beach, 333 passed and have been issued licenses to practice medicine in Florida. The names of addresses of the 333 successful applicants follow:

Alfonso, Alvaro, West Palm Beach (National U. of Colombia 1949)
Alving, Ralph Eric, Miami (Columbia U. 1959)
Anderson, William Way, Miami (U. Louisville 1959)
Angelucci, Helen Marguerite, Fort Lauderdale (Woman's Med. Col. Pennsylvania 1927)
Armistead, James Davenport, Sebring (Emory U. 1960)
Armstrong, Louis Field, Plant City (U. of Miami 1960)
Bailey, William Ross Jr., Jacksonville (U. Florida 1960)
Baker, James Alva, Jacksonville (U. Miami 1960)
Baker, Marvin Israel, Jacksonville (U. Florida 1960)
Barancik, Maurice, Coral Gables (Northwestern 1960)
Barrow, Mark Velpeau, Sr., Crestview (U. Florida 1960)
Baumgarten, Harold, Miami (U. Miami 1960)
Baxter, Cecil Frederick, Gainesville (Harvard 1943)
Becker, Bruce Andrew, N. Babylon, N. Y. (U. Vermont 1955)
Beckmeyer, William Joseph, Fort Thomas, Ky. (Georgetown 1955)
Bennett, Etta Jean Lester, Gainesville, (U. Florida 1960)
Bernstein, Stuart Paul, Jacksonville (George Washington U. 1957)
Betcher, Albert Maxwell, New York (St. Louis U. 1935)
Blakey, Billy Ray, Orlando (U. Florida 1960)
Bleech, David Merle, Pahokee (U. Miami 1960)
Blick, Michael Samuel, Eggertsville, N. Y. (New York Med. Coll. 1937)
Blodgett, George Sumner, III, West Palm Beach (U. Miami 1960)
Bloom, Eugene Charles, Fort Lauderdale (U. Miami 1960)
Blum, Morton, Forest Hills, N. Y. (Albert Einstein Col. Med. 1960)
Boley, Santford Ripley, Miami (Wayne St. U. 1958)
Bong, Gary Michael, Miami (U. Miami 1960)
Bonner, Octavius Blanchard Jr., High Point, N. C. (Duke U. 1953)
Bono, Irvin David, Jacksonville, (U. of Miami 1960)
Bowen, Alfred Christian, Miami (U. Miami 1960)
Bradley, William Joseph III, Woodbury, Ga. (M.C. Ga. 1955)
Brame, Charles Lowel, Orlando (U. Miami 1960)
Branyon, Donald LeRoy Jr., Jacksonville (M.C. Ga. 1959)
Braunstein, Jonathan Jay, Miami (U. Miami 1960)
Brewer, Robert Allen, St. Petersburg (Indiana U. 1955)
Briant, Thomas Paul, Decatur, Ga. (Emory U. 1960)
Bridges, Barnard Tillman Jr., Birmingham, Ala. (N.Y.M.C. 1958)
Brown, Charles Seignious, Tampa (M.C.S. Carolina 1959)
Brown, Eli Hinson, Coral Gables (U. Miami 1960)
Brown, Warren Franklin, Atlanta, Ga. (U. Tenn. 1954)
Buttram, Thomas Latham, Fort Benning Ga. (Emory U. 1953)
Butts, James Allen, Atlanta, Ga. (Emory U. 1960)
Campbell, Selma Ronald, Fort Benning, Ga. (U. Miami 1960)
Carswell, Abel Paul Jr., Miami (Duke U. 1956)
Carter, Vernon Henry Jr., Little Rock, Ala. (U. Arkansas 1959)
Cary, Freeman Hamilton, Orlando (Emory U. 1950)
Chastain, Doyle Edward, Lake Wales (U. Miami 1960)
Cohen, Lawrence Samuel, Shaker Heights, Ohio (Vanderbilt U. 1960)
Cohen, Marshall, Richmond, Va. (M.C. Ga. 1958)
Cole, Edward Fowler, Orlando (Vanderbilt 1960)

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Affiliates of Black & Skaggs Associates

Coleman, John Alexander Jr., Plant City (Tulane U. 1960)
Conkling, Sarah Pamelia Leech, Miami (George Washington U. 1956)
Conlon, Harold Jay, Lakeland (U. Cincinnati 1945)
Constantine, Thomas Moore, Jacksonville (Duke U. 1954)
Crawford, Glenn Dale, Tampa (Emory U. 1960)
Cremata, Vincent Young Jr., Gainesville (U. Florida 1960)
Creston, James Ernest, W. Hollywood (U. Pittsburgh 1958)
Curry, Calvin Horace Jr., Quincy (Johns Hopkins 1960)
Daeppen, Charles Rudolf, Howell, Mich. (U. Zurich 1952)
Dain, Harvey Joshua, New York (U. Philippines 1940)
Dalton, Martin Lester Jr., Jackson, Miss. (M.C. Alabama 1957)
David, Arthur Kalil Jr., Jacksonville (Duke U. 1960)
Davis, Jack Alan, N. Miami Beach (Temple U. 1960)
Dillard, Richard Lynn, Springfield, Tenn. (U. Tenn. 1959)
Dockery, Junior Lee, Miami (U. Arkansas 1957)
Doenges, John Pell, Olney, Ill. (U. Maryland 1945)
Dowling, George Warren, Kermit, Tex. (Loyola U. 1952)
Drylie, David Marsh, Gainesville (Bowman Gray 1956)
Duke, James Roy Jr., Lakeland (Tulane 1960)
Eberly, Arthur Lee Jr., Lakeland (U. Miami 1960)
Eckels, Alan Ronald, Jacksonville (U. of Florida 1960)
Edelson, Stuart Roy, White Plains, N. Y. (U. Louisville 1959)
Ellis, Forrest Daryel, Homestead AFB (Indiana U. 1957)
Elstun, Wesley Bryan, Hammond, Ind. (Northwestern 1952)
Elton, Sanford Elson, St. Petersburg (Northwestern 1959)
Engle, Mary Allen English, New York (Johns Hopkins 1945)
Entel, Irwin Leonard, Brooklyn (U. Geneva 1957)
Farmer, Charles Baring, Miami (U. Miami 1960)
Fedor, Richard Ernest, S. Miami (U. Miami 1959)
Ferber, Carl Jacob, Cleveland (Western Reserve U. 1946)
Ferrer, Meneses, Luis Manuel, Miami (Havana U. 1953)
Fischer, Robert Wallace, Miami (Duke U. 1960)
Fleites, Juan Arredondo, Fort Lauderdale (U. Havana 1948)
Foust, Betty Jean, Collingswood, N. J. (Indiana U. 1957)
Fox, Channing Henry, Miami (U. Miami 1960)
Free, Harry James, Gainesville (U. Florida 1960)
Friedman, Murry Nathan, Brooklyn (N.Y.U. 1943)
Gadboys, Howard Leonard, Coral Gables (Boston U. 1951)
Garlington, James Conway, Ocoee (Yale U. 1955)
Gersh, Herbert, Miami (U. Vermont 1955)
Gilchrest, James Warren, Greensburg, Pa. (U. of Pittsburgh 1944)
Gilman, Steve Hoyt, Tampa (U. Florida 1960)
Giordano, David Alfred, Durham, N. C. (Indiana U. 1955)
Golden, Howard, Miami (U. Miami 1960)
Goldstein, Arthur, Hollywood (U. Illinois 1960)
Goldstein, Burton Jack, Coral Gables (U. Maryland 1960)
Goldstein, Marvin Irving, Miami (U. Miami 1960)
Goodman, Stanley Sidney, Miami (St. U. N. Y. 1955)
Gordon, Meryl, Coral Gables (U. Miami 1960)
Grace, John Thomas, Marianna (U. Colo. 1958)
Gratz, Charles Jay, Miami Beach (Tulane U. 1960)
Griffin, William Vivian, III, Miami Beach (Emory U. 1960)
Gup, Alex Kramer Meyer, Pensacola (Emory U. 1960)
Gustafson, William Louis Jr., Miami (State U. N. Y. 1959)
Gutierrez, Gervasio Guzman, New York (U. Havana 1951)
Gutman, Elliott Michael, Miami (U. Miami 1960)
Hahn, Robert Emil, White Plains, N. Y. (Creighton U. 1958)
Hammer, Wray Allen, Fort Lauderdale (Emory U. 1960)
Hanley, John Patrick III, New Orleans (Tulane U. 1960)
Hanson, James Dewey, Miami Shores (U. Miami 1958)
Harris, Jeff Williams, New Orleans (Johns Hopkins 1952)
Harrison, Charles Elbert Jr., St. Petersburg (Emory U. 1960)



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Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

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Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

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Upjohn

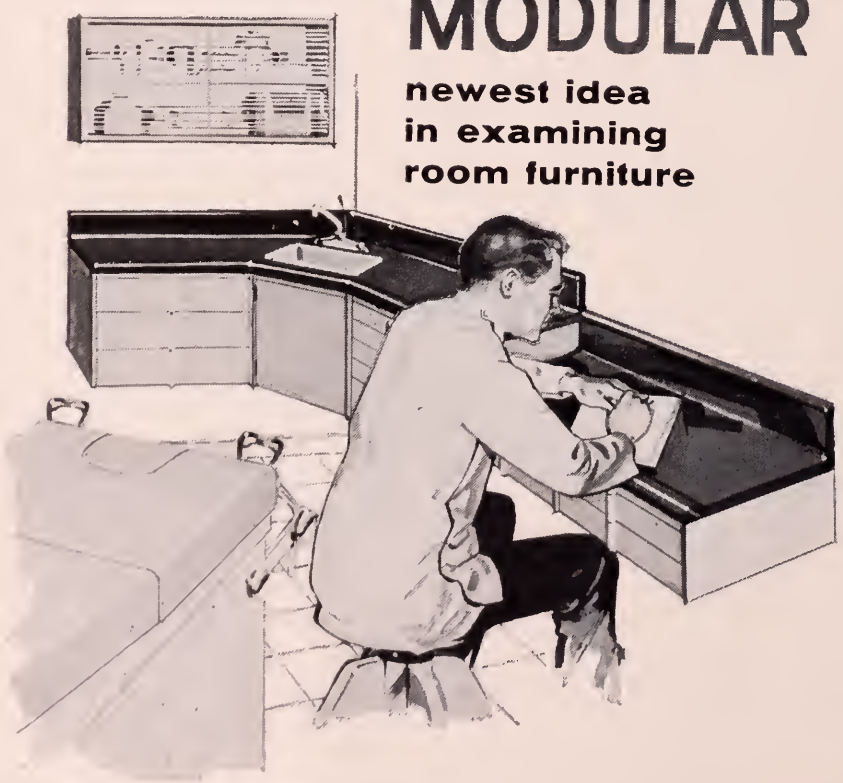
Heilman, Richard Bancroft, Atlanta, Ga. (U. Wisc. 1943)
Herrero, Brunildo Antonio, Miami (U. Florida 1960)
Herz, Ralph Jr., New York (Western Reserve 1953)
Hilbert, John Frederick, Atlanta, Ga. (Emory U. 1960)
Hillman, David Carl, Miami Beach, (U. Miami 1960)
Hiribarne, Pedro Fernando, Orlando (U. of Miami 1958)
Hogan, Walter Leroy Jr., Dallas, Tex. (M. C. Ala. 1957)
Holcomb, Allen Keith, Orlando (Emory U. 1960)
Holman, Franklin Pierce, Jacksonville (U. of Miami 1960)
Hoover, Walter Boyd Jr., Boynton Beach (Tufts U. 1953)
Hoppenfeld, Stanley, New York (Chicago Med. Sch. 1959)
Hunter, Richard Devois (Col.) Jacksonville (Meharry 1959)
Hurlburt, James Cole, Chapel Hill, N. C. (Duke U. 1958)
Hussey, Michael Ignatius, North Miami (Loyola U. 1957)
Jackson, Chrisman Spears Jr., Miami (U. Louisville 1959)
Jackson, Louise Oftedeal, Pompano Beach (George Washington U. 1949)
Jacobs, Robert Harry, Miami (U. Miami 1960)
James, Edward Milo, Savannah, Ga. (U. Miami 1960)
Jamieson, Robert Bruce Jr., Tangerine (Yale U. 1937)
Jarvis, Garth Louray, Galveston, Tex. (U. Michigan 1943)
Johnson, James Monroe, West Palm Beach (U. Miami 1960)
Johnson, Rand Carleton, St. Petersburg (Northwestern 1949)
Jonas, Adolph Garland Jr., Ponte Vedra Beach (Vanderbilt 1956)
Jones, Beverley Bryan, Miami (U. Va. 1954)
Jones, Billy Ernest, Daytona Beach (Duke U. 1958)
Jordan, Paul Howard Jr., Gainesville (U. Chicago 1944)
Kaminstein, Philip, Coral Gables (State U. N. Y. 1952)
Kann, Jules, Miami Beach (U. Basel 1959)
Kasnetz, Herbert Roy, Brooklyn (N. Y. M. C. 1960)
Katzen, Melvyn Joel, Miami Beach (U. Miami 1960)
Kempers, Roger Dyke, Lakeland (Wayne State U. 1954)
Kester, Richard Joseph, Jacksonville (Jefferson M.C. 1951)
Kiester, Kenneth Dwight Jr., Orlando (Oklahoma U. 1959)
King, Elmer Henry, Gainesville (Columbia U. 1955)
Koenig, Robert Louis, Mary Esther (Southwestern M. C. 1946)
Kohl, Stanley, Coral Gables (U. Zurich 1959)
Koon, Wiley Emmett, Lakeland (U. Miami 1960)
Kroll, Arnold Joseph, Miami Beach (Columbia 1960)
Kublin, John George, Detroit (U. Mich. 1960)
Kucera, Frank Edward, Delray Beach (U. Mich. 1955)
Kuhn, Beatrice Hart, Charleston, W. Va. (Duke U. 1943)
Lawrence, Duard, Miami (U. Louisville 1959)
Leatherman, James Wilson, Hot Springs, Ark. (U. Tenn. 1940)
Lemmert, William Arden, Tampa (U. Maryland 1956)
Lenton, Charles Trewartha Jr., Charlottesville, Va. (U. Penna. 1952)
Leonard, Samuel Anderson, New Orleans (Tulane U. 1960)
Lerner, George Gershon, Miami (Syracuse U. 1950)
Levine, Robert Allan, Cleveland Heights, Ohio (Howard U. 1959)
Lichtenstein, Robert Simeon, Fairfield, Conn. (Harvard U. 1952)
Liebman, Norman Charles, Miami (U. Penna. 1959)
Lighterman, Irwin, Miami (N. Y. U. 1958)
Lockhart, Herbert Garrison Jr., Linwood, N. J. (Temple U. 1955)
Logsdon, Donald Neil, West Palm Beach (U. Florida 1960)
Lutzner, Marvin Allen, Miami (Hahnemann 1955)
Luxenberg, Malcolm Neuwahl, Cincinatti (U. Miami 1960)
Lyons, Henry Richard, Washington, D. C. (Georgetown 1945)
Mahoney, William Dunvar, Venice (N. Y. M. C. Flower 5th Hosp. 1959)

(Continued on page 470)

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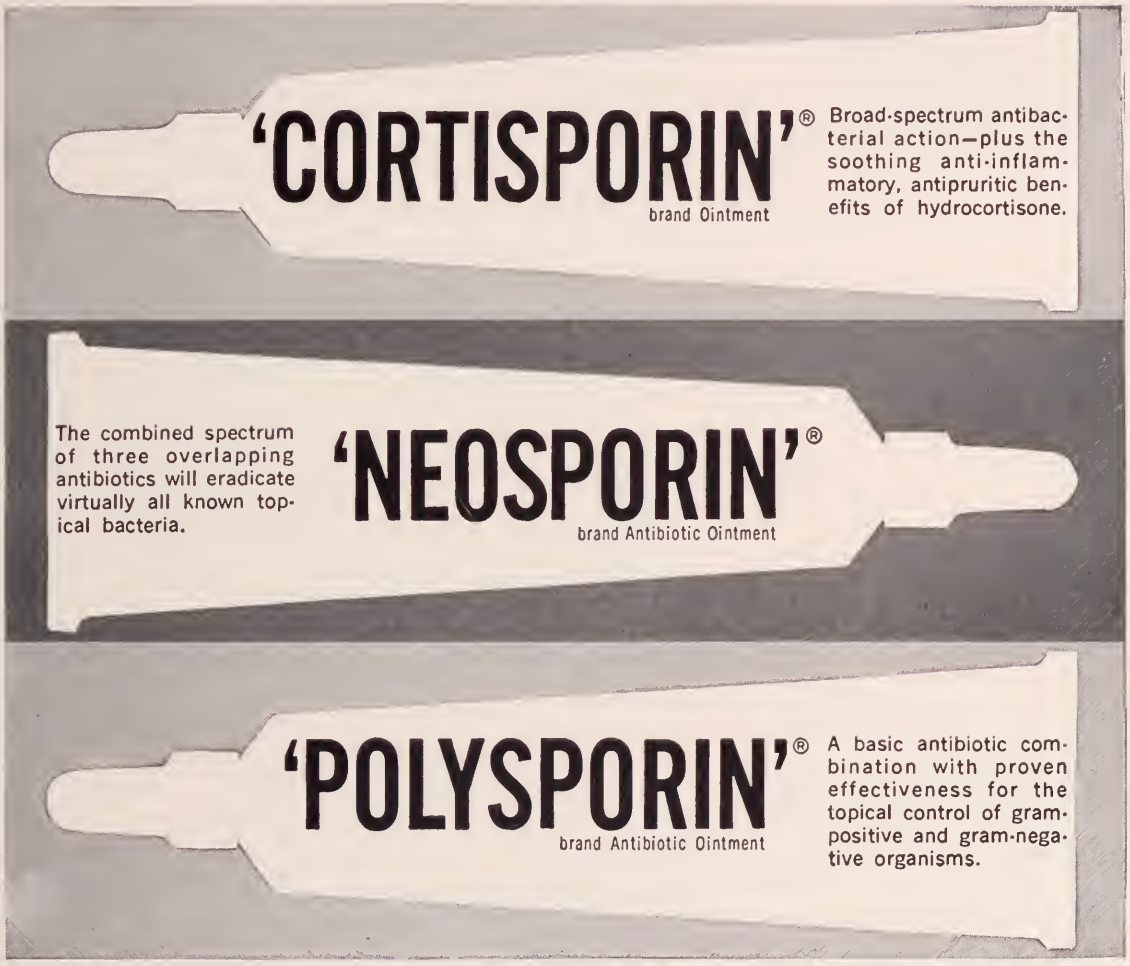
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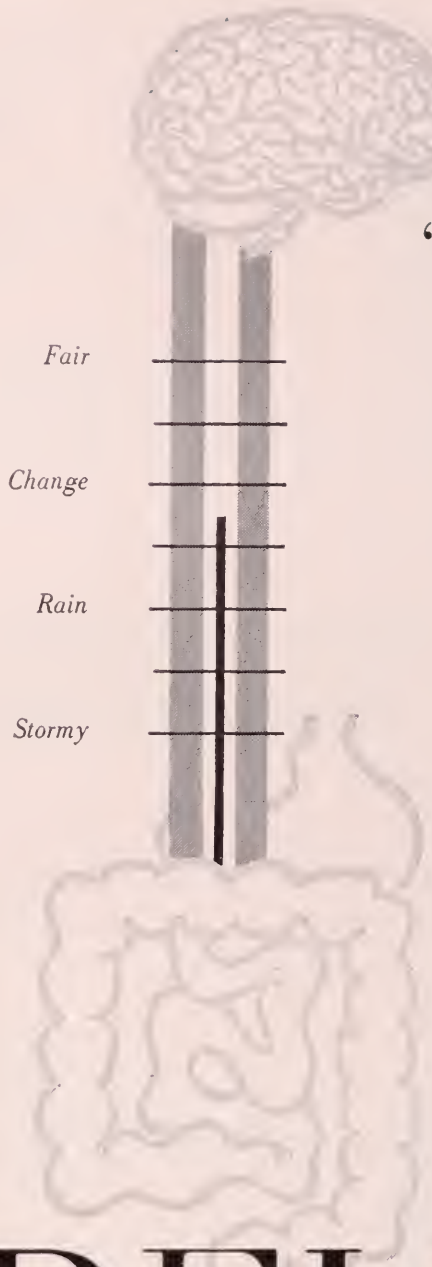
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Such were the aesthetic gains. Behind these, a significant pharmaceutical advance: with Filmtab, deterioration is slowed to an irreducible minimum, because the coating process is essentially a water-free procedure.

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EACH DAYTEENS FILMTAB® REPRESENTS:

Vitamin A	(5000 units) 1.5 mg.
Vitamin D	(1000 units) 25 mcg.
Thiamine Mononitrate (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Nicotinamide	20 mg.
Pyridoxine Hydrochloride	0.5 mg.
Vitamin B_{12} (as cobalamin concentrate)	2 mcg.
Calcium Pantothenate	5 mg.
Ascorbic Acid (C)	50 mg.
Iron (as sulfate)	10 mg.
Copper (as sulfate)	0.15 mg.
Iodine (as calcium iodate)	0.1 mg.
Manganese (as sulfate)	0.05 mg.
Magnesium (as oxide)	0.15 mg.
Calcium (as phosphate)	250 mg.
Phosphorus (as calcium phosphate)	193 mg.

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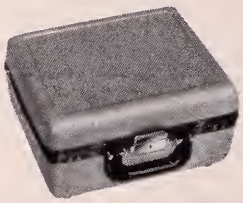


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1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

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VOLUME XLVII
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of clinical use...

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

WALLACE LABORATORIES / *Cranbury, N. J.*

*TRADE-MARK

CM-2838

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

contain
the
bacteria-prone
cold

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)



inner
protection
with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

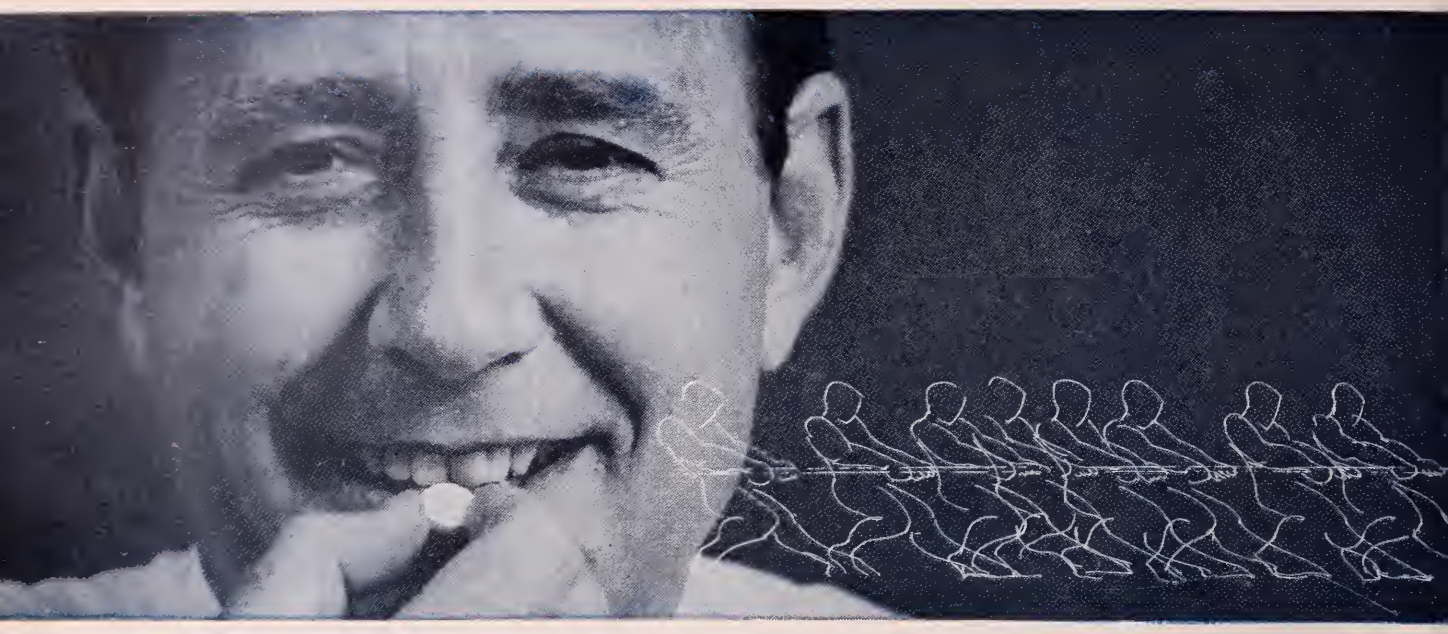
well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · Lincoln, Nebraska
a division of The Wander Company

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

Palatable
'Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M. R. Thompson, Inc.* CRANFORD, N. J.



Variety is the spice in this diet! Meat patties, peas and carrots, baked potato, gelatin salad, applesauce dessert—and beer.

The secret of a successful bland diet is acceptance

So appetizing (and therefore so acceptable)—broiled meat patties, made tender with crushed corn flakes and water, tasty with salt, savory with a hint of thyme or marjoram. Fish soufflé—delicious when the top is crisped with cracker meal and butter!

Bland but satisfying are asparagus tips, carrots, and peas—served whole if tender, or puréed. Potatoes may be boiled, baked or mashed. Molded gelatin salads are pretty to look at—better to eat. For dessert, how about applesauce added to whipped lime gelatin and topped with custard sauce?



And with your approval, a glass of beer can add zest to your patient's diet

pH 4.3
(Average of American Beers)

United States Brewers Foundation

If you'd like reprints of this and 11 other different diet menus for your patients, write United States Brewers Foundation, 535 Fifth Avenue, N.Y. 17, N.Y.

VOLUME XLVII
NUMBER 4



WHEN ULCEROGENIC FACTORS KEEP ON WORKING...



REMEMBER THIS: SO DOES ENARAX

Think of your patient with peptic ulcer—or with gastrointestinal dysfunction—on a typical day.

Think of the anxieties, the tensions.

Think, too, of the night: the state of his stomach emptied of food.

Disturbing?

Then think of ENARAX. For ENARAX was formulated to help you control precisely this clinical picture. ENARAX provides oxyphencyclimine, the inherently long-acting anticholinergic (up to 9 hours of actual achlorhydria[1]) . . . plus Atarax, the tranquilizer that doesn't stimulate gastric secretion.

Thus, with b.i.d. dosage, you provide continuous antisecretory/antispasmodic action and safely alleviate anxiety . . . with these results: ENARAX has been proved effective in 92% of G.I. patients.[2-4]

When ulcerogenic factors seem to work against you, let ENARAX work for you.

ENARAX® B.I.D.

(10 MG. OXYPHENCYCLIMINE PLUS 25 MG. ATARAX®†) A SENTRY FOR THE G.I. TRACT

dosage: Begin with one-half tablet b.i.d. — preferably in the morning and before retiring. Increase dosage to one tablet b.i.d. if necessary, and adjust maintenance dose according to therapeutic response. Use with caution in patients with prostatic hypertrophy and only with ophthalmological supervision in glaucoma.

supplied: In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Steigmann, F., et al.: Am. J. Gastroenterol. 33:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

†brand of hydroxyzine

FOR HEMATOPOIETIC STIMULATION
WHERE OCCULT BLEEDING IS PRESENT
HEPTUNA® PLUS
THE COMPLETE ANEMIA THERAPY

ROERIG
New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

Sun. Mon. Tue. Wed. Thur. Fri. Sat.

Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

[redacted]

in premenstrual tension only neo Bromth treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee



IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from 1/8% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride
NASAL SOLUTIONS AND SPRAYS



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.— METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn



The basic question is whether we are to discard the system that has brought us to our present level of health care, and promises much higher levels for the future, in favor of a regulatory strait jacket that stifles initiative, bureaucratizes research, and promises nothing for the future.

You can't go places in a strait jacket...!

An editorial writer recently made the interesting suggestion that the pharmaceutical industry might have avoided much of the current public interest in its affairs if they had simply restricted themselves to making aspirin tablets and rubbing alcohol, competing only by debating which aspirin dissolves faster. • No one has seriously suggested a return to the "good old days" in therapeutics, but there are apparently some who would like to destroy the system that has produced for us the finest medical care in the history of the world. Whether they attack the freedom of the patient to choose his physician, the freedom of the physician in the practice of his profession, or the freedom of the pharmaceutical industry is immaterial. • If the desideratum is simply maintenance of the status quo in health care, medicine might well have rested on its 19th century laurels and the pharmaceutical industry on aspirin tablets and rubbing alcohol.

This message is brought to you on behalf of the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.


Trancopal®
brand of chlormezanone
effective oral skeletal
muscle relaxant
and tranquilizer
LETS THE PATIENT WALK
"HEADS UP"
in spite of torticollis.



Trancopal

relieves pain and spasm associated with torticollis.

In a recent study by Ganz, Trancopal brought considerable improvement or very effective relief to 20 of 29 patients with torticollis.[1] "The patients helped by the drug," states Ganz, "were able to carry the head in the normal position without pain." Similarly, Kearney found that in 8 of 13 patients with chronic torticollis treated with Trancopal improvement was excellent to good. ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[2]

Lichtman, in a study of patients with various musculoskeletal conditions, noted that 64 of 70 patients with torticollis obtained excellent to good relief with Trancopal.[3]

In a comparative study of four central nervous system relaxants, Lichtman reports that 26 of 40 patients found Trancopal to be the most effective drug.[3]

1. Ganz, S. E.: *J. Indiana* . A 52:1134, July, 1959. 2. Kearney, D. *Current Therap. Res.* 2:127, 1960. 3. Lichtman, A. L.: *Ke* *Acad. Gen. Pract. J.* 4:28, Oct.,

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off. 4716

Clinical results with Trancopal®[2]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.

Why diet is preferable to drugs

...in the control of serur

The objective of therapy is the approximation of the physiological norm.

This is most satisfactory when it can be accomplished by dietary manipulation. The control of elevated serum cholesterol through relatively simple changes in the dietary pattern of the patient puts nature's own processes to work most effectively to achieve the objectives of treatment.

The dietary approach does more than correct the serum cholesterol problem. Because overweight, together with improper eating patterns, is so often involved, the prescription of corrective diet helps the patient to help himself by establishing sound nutritional practices.

For the prophylaxis and prevention of hypercholestemia, the dietary approach affords the advantages of simplicity and economy. Diet therapy is for the long-term management of a chronic condition, while drug therapy is most efficient for acute situations.

The development of atherosclerosis is a slow process. It is believed that the onset of this condition is in early adulthood, but its clinical symptoms take as many as 20 years to manifest themselves. Simple changes in diet serve to keep the blood cholesterol concentration at an acceptable level.

Dietary therapy has other significant advantages over medication as follows:

1. Dietary adjustment involves little or no expense to the patient, whereas drugs are costly.
2. Dietary therapy may be made with complete safety—even for pregnant females.
3. Dietary therapy produces no side effects, whereas there is not as yet sufficient clinical evidence as to the long-term effects of drugs.
4. Dietary therapy brings about reduction in serum cholesterol through normal body processes, as yet not fully understood. On the other hand, some drugs can leave in the body accumulations of cholesterol precursors.
5. Dietary procedures do not usually generate new compounds in the blood which interfere with the chemical determination of blood serum cholesterol.
6. Dietary therapy offers a solution to the related problems of obesity which drugs do not.

Elevated serum cholesterol has long been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through control of total calories and through replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil. An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

* * *

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

ROCK CORNISH GAME HENS—Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.

More acceptable to patients. Wesson is preferred for its supreme delicacy of flavor, increasing the palatability of food without adding flavor of its own.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of high iodine number are selected for Wesson, and no significant variations are permitted in the 22 exacting specifications required before bottling.

Economy. Wesson is consistently priced lower than the next largest seller.

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

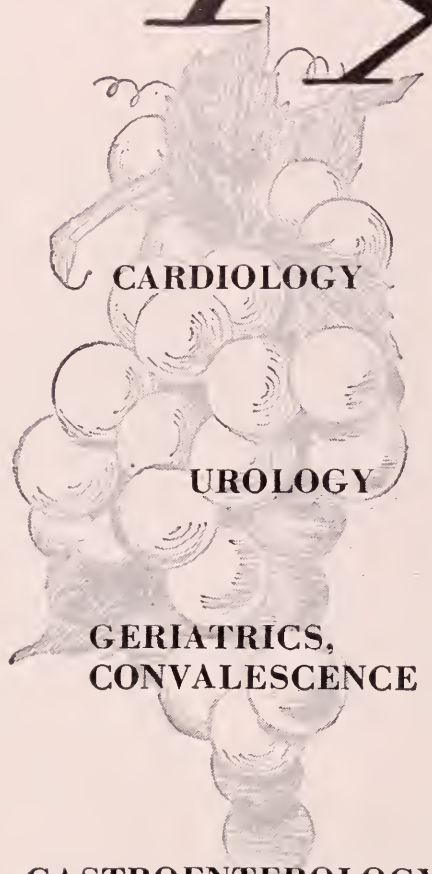
Never hydrogenated—completely salt free

holesterol



Rx

Recent research* confirms the widening FIELD for WINE



CARDIOLOGY

UROLOGY

GERIATRICS, CONVALESCENCE

GASTROENTEROLOGY

DIABETES

WINE has been used with excellent effect for the relief of pain, discomfort, apprehension and anxiety in angina pectoris, thromboangiitis obliterans, Raynaud's disease and hypertension.

The judicious use of WINE can brighten the otherwise monotonous, unappealing diet in renal disease. It increases glomerular blood flow, stimulates diuresis, is nonirritating to the kidneys.

By stimulating appetite, supplying quick energy source, relaxing tensions and increasing morale, the prudent use of WINE has been described as a balm for the convalescent and "milk" for the aged.

In moderate amounts WINE increases gastric secretion, relaxes gastric tension and, therefore, is a valuable aid in the treatment of anorexia, hypochlorhydria, dyspepsia, spastic constipation and diarrhea.

In the normal diet of the diabetic, WINE can serve as an excellent energy source which does not require the participation of insulin.

These and other therapeutic uses for wine are discussed in *"Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes. . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL[1]. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

(Continued from page 442)

Mangus, Jimmie Lee, Charleston, W. Va. (M. C. Va. 1959)
Mansell, John Lawson, Sanford (U. Penna. 1958)
Marcadis, Abe, Miami (U. Miami 1960)
Margolin, Frederick Ronald, Los Angeles (U. Miami 1960)
Margulies, Stanley Ira, Baltimore (Johns Hopkins 1960)
Markarian, Berge Harootium, Miami (U. Istanbul 1952)
Markman, Ira Eugene, New York (Chicago Med. Sch. 1959)
Mathews, Hurschell Frederick, Tampa (Bowman Gray 1960)
McConnell, James Franklin, Fort Lauderdale (Indiana U. 1959)
McCree, Douglas Gene, Oakland, Calif. (Emory U. 1957)
McLain, Arthur Lee, Tampa (U. Kansas 1957)
McLaughlin, Bernard Hugh, Eagle Lake (Temple U. 1954)
McLeod, Michael Eugene, Ft. Pierce (Duke U. 1960)
McMechan, David Robinson, Tampa (U. Mich., 1959)
McMurrain, Key David Jr., San Antonio, Tex. (Tulane U. 1958)
Mela, Henry Jr., St. Petersburg (U. Miami 1960)
Mendelblatt, Frank Irving, St. Petersburg (U. Miami 1960)
Menzel, Richard Edward, Miami (Georgetown 1957)
Merrell, Robert Alston Jr., New Haven, Conn. (Duke U. 1960)
Metzger, Charles Robert Jr., St. Petersburg (U. Florida 1960)
Miller, Gordon Roth, Miami (Washington U. 1960)
Mitchell, Fenton Martin, Norfolk, Va. (U. Pittsburgh 1957)
Mitchell, William Marvin, Baltimore (Vanderbilt 1960)
Mitchell, Williams Scales Jr., Orlando (Emory U. 1960)
Mcench, George Cornelius, Treasure Island (U. Mich. 1958)
Moles, Stanley Sylvester, Gainesville (Duke U. 1959)
Muldrow, Louis Meriwether Jr., Jasper, Ala. (Vanderbilt 1960)
Muller, Walter Joseph III, Winter Park (Emory U. 1960)
Musinger, Jules, Miami Beach (N. Y. U. 1960)
Myers, Milton Bernard, Miami (U. Geneva 1956)
Nesmith, Marsh Arthur Jr., Plant City (Duke U. 1959)
Newman, Daniel Marquette, Fort Lauderdale (Indiana U. 1958)
Nicely, Donald Alvin, Monaca, Pa. (U. Pittsburgh 1957)
Nixon, William Anthony, Hialeah (U. Miami 1960)
Noah, Garrell Cela, Durham, N. C. (Emory U. 1959)
Nohr, David Albert, Perrine (U. Lausanne 1958)
Nolan, Raymond Paul, Pelham Manor, N. Y., (N. Y. U. 1951)
Nolan, Thomas Robert, Cleveland Heights, Ohio (St. Louis U. 1948)
Norenberg, Richard George, Tampa (U. Illinois 1959)
North, Luceil Bauer (f), Atlanta, Ga. (M. C. Ga. 1956)
Nystrom, Robert Bruce, Miami (Northwestern 1957)
Oberdorfer, Paul William, Jacksonville (Tulane U. 1960)
O'Brien, James Neil, Tampa (Marquette U. 1958)
O'Brien, John Stanley, Hartford, Conn. (U. Penna. 1959)
Ohlwiler, David Austin, St. Louis (U. Rochester 1954)
O'Lone, Joseph Patrick, Miami (U. Miami 1960)
O'Neal, Edwin Earl, Orlando (Tulane U. 1959)
Orgusaar, Rudolph, Woonsocket, S. D. (U. Erlangen 1949)
Orr, Louis McDonald Jr., Orlando (Emory U. 1960)
Ozaki, Charles Takeo, Gainesville (U. Florida 1960)
Paquelet, Charles John, Massilon, Ohio (Ohio State U. 1959)
Patterson, Joseph Richard, Tampa (Tulane U. 1958)
Patterson, Sam Polk, Memphis, Tenn. (U. Tenn. 1955)
Pearson, Clarence Arthur, Naples (U. Rochester 1960)
Pence, Robert Edward, Miami (U. Penna. 1954)
Pepus, Martin, Miami (U. Miami 1960)

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PROFESSIONAL LIABILITY INDIVIDUAL INSURANCE

by

*"The No. 1 Malpractice Insurer"**

*MEDICAL ECONOMICS, FEB. 3, 1958

Unparalleled Experience • Specialized Service • Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep.
149 Northwest 106th Street, Miami Shores
Tel. Plaza 4-2703

in rheumatic disorders

whenever aspirin proves inadequate



Sterazolidin®
brand of prednisone-phenylbutazone

Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60

Pichel, Richard Sigmund, North Miami (U. Lausanne 1957)
Pittman, Frank Smith III, Atlanta, Ga. (Emory U. 1960)
Powell, Louis Frederick Jr., Jacksonville (M. C. Ga. 1959)
Privitera, Louis Michael, Buffalo (St. Louis, 1943)
Pryor, Howard Irwin, Tampa (U. Florida 1960)
Putter, Pierre Jacques, Miami Beach (State U. N. Y. 1956)
Qualey, John Robert, Cleveland Heights, Ohio (U. Cincinnati 1956)
Radin, Eric Leon, Los Angeles (Harvard U. 1960)
Raia, Louis Joseph, Tampa (U. Illinois 1959)
Rappaport, Martin Paul, Miami Beach (Tulane U. 1960)
Raskin, Robert Benjamin, Miami Beach, (U. Miami 1960)
Rasmussen, Eyvin Paul, Punta Gorda (U. Florida 1960)
Raulerson, Hiram Henry Jr., Okeechobee (U. Miami 1960)
Rawdin, Kenneth Stuart, Miami (Albert Einstein Col. Med. 1959)
Read, Robert Mendel, Charleston, S. C. (M. C. S. Carolina 1956)
Reed, John Martin, Louisville, Ky. (U. Louisville 1960)
Reeves, Robert Percy Thomas, New York (U. Penna. 1953)
Reich, Jerome S., Bayside, N. Y. (Tulane U. 1960)
Reid, Edward Leonidas II, Miami (U. Penna. 1959)
Reid, Jack Melvin, Jacksonville (U. Miami 1960)
Reina, Domenick Peter, Tampa (Tulane U. 1960)
Resnik, Harvey Lewis Paul, Miami (Columbia 1955)
Rhodes, Jess Fred, Shaker Heights, Ohio (Ohio State U. 1959)
Richter, Allen Edwin, Buffalo (U. Buffalo, 1920)
Rieman, Robert Donald, Homestead AFB, (Northwestern U. 1956)
Risi, George Franklin, Jacksonville, (Jefferson M. C. 1948)
Robinson, Bettie, Jacksonville (U. Florida 1960)
Roehm, Dan Christian, Lake City (Western Reserve U. 1947)
Rogers, William Plummer, Isle of Palms, S. C. (M. C. S. Carolina 1959)
Rohan, Neil John, Miami (U. Florida 1960)
Rolfs, Herman Emil, Pensacola (U. Miami 1960)
Rosenberg, Elias William, Miami (U. Penna. 1956)
Rosenfeld, Harry, Miami (U. Illinois 1956)
Ross, John Joseph, Jacksonville (Harvard U. 1956)
Rowe, Luther Conrad, Tampa, (M. C. Ala. 1959)
Royal, David Stanley, Umatilla (Tulane U. 1960)
Rush, Elizabeth Ann, Bonita Springs (U. Miami 1960)
Salzman, Robert Theodore, Miami (Tulane U. 1960)
Sanders, Gerald Sidney, Miami (U. Miami 1960)
Sasser, James Archibald Jr., Miami (M. C. S. Carolina 1959)
Savage, James Fred Jr., Tampa (U. Miss. 1959)
Scalettar, Raymond, Hyattsville, Md. (State U. N. Y. 1954)
Schaefer, Joseph Charles, Jacksonville (U. Wisc. 1950)
Schild, Arnold Frederick, Miami (M. C. S. Carolina 1957)
Schlang, Henry Aloysius, Jacksonville (Albany M. C. 1944)
Schwartz, Norman Alvin, McKeesport, Pa. (Ohio State U. 1942)
Schwartzman, Morton Nathan, Miami (U. Miami 1960)
Seeger, Frank Louis Jr., Memphis, Tenn. (U. Tenn. 1960)
Selle, Harold Charles, St. Louis (St. Louis U. 1943)
Senfield, Richard Maxon, Miami (Yale U. 1959)
Sever, Raymond Joseph, Hialeah (U. Miami 1960)
Shafer, William Albert, Erie, Pa. (U. Pittsburgh 1943)
Shanklin, Douglas Radford, Gainesville (State U. N. Y. 1955)
Shocket, Everett, Miami (Long Island M. C. 1948)
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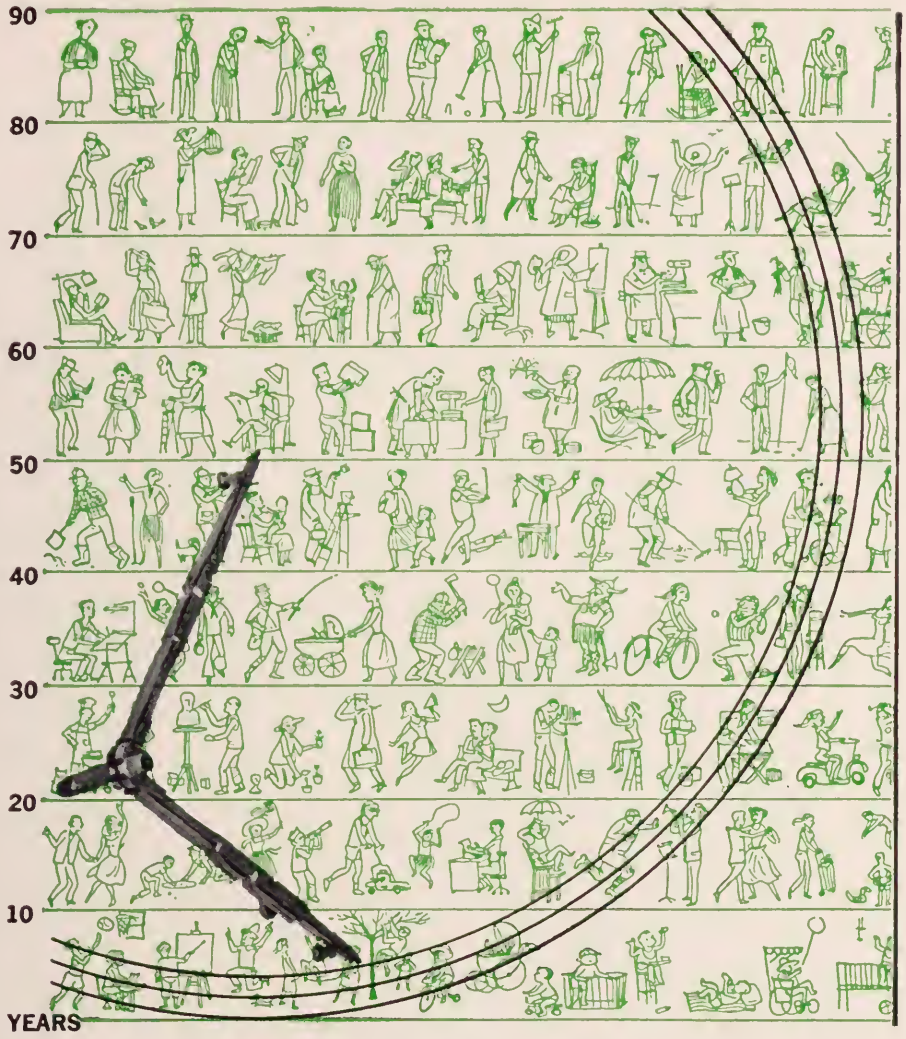
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Smith, James Allen III, Macon, Ga. (Emory U. 1960)
Smith, Samuel Walker, Miami (U. Florida 1960)
Smock, Sidney Newberry, Ann Arbor, Mich. (U. Mich. 1960)
Snedeker, Bernard Carlton, Detroit (U. Mich. 1936)
Sobel, Arnold Meyer, Fort Campbell, Ky. (N. Y. U. 1955)
Sorosky, Arthur Dean, Los Angeles (U. Miami 1960)
Sotus, Peter Chris, Atlanta, Ga. (Emory U. 1956)
South, Edward Plumstead, Winter Haven (Hahnemann 1956)
Stahl, Norman Oscar, Brooklyn (Tulane U. 1958)
Stanford, Carol Carson, Jacksonville (Coll. Med. Evan. 1955)
Stanford, Thomas Albert, Jacksonville (Coll. Med. Evan. 1955)
Stephens, Hinson Lafayette, Jacksonville (U. Miami 1960)
Susong, William Anderson, Dallas, Tex. (U. Tenn. 1953)
Sweat, Arthur Warren, Largo (U. Florida 1960)
Tanenbaum, Mark Harris, Miami Beach (U. Miami 1960)
Taylor, Donald Willis, Ferndale, Mich. (Bowman Gray 1958)
Thorrens, Sheldon Jerome, Miami (Northwestern 1960)
Tobias, Donald A., Forest Hills North, N. Y. (Northwestern 1959)
Toker, Donald Leo, Miami (Western Reserve U. 1950)
Toledo, Florentino Humberto, Tampa (U. Havana 1953)
Traxler, Malcolm MacDougall, Gainesville (Emory U. 1960)
Trombino, James Frederick, Detroit (Hahnemann 1938)
Tufts, Thomas Wilson, Coral Gables (Ohio State U. 1959)
Turk, Lucas Newton III, Atlanta, Ga. (Emory U. 1952)
Turner, Leonidas Martin Jr., Tampa (U. Miami 1960)
Twente, Elmer William, East Syracuse, N. Y. (U. Kansas 1956)
Waldrop, Charles Wesley Jr., Miami (U. Louisville 1959)
Walton, Bruce Eugene, Gainesville (Western Reserve U. 1955)
Webb, Howard Warner, Decatur, Ga. (Emory U. 1957)
Weiner, Frieda Molly, Chicago (U. Illinois 1952)
Welch, George Harrison Jr., Durham, N. C. (Duke U. 1953)
Whalen, Charles Peter, Kankakee, Ill. (U. Illinois 1931)
Whiddon, Roscoe Owens, Tallahassee (U. Miami 1960)
Whitehurst, John Onan, Brooksville (U. Florida 1960)
Whittier, Millicent Kay Miller, Gainesville (U. Florida 1960)
Williams, John Webster Jr., Jacksonville (U. Miami 1960)
Williams, Robert Edwin, Homestead (George Washington U. 1956)
Wilson, John Thomas, Lake City (Albany M. C. 1954)
Wilson, Santford Russell Jr., Gainesville (U. Florida 1960)
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Wolfgram, Edwin Dale, Miami (State U. Iowa 1959)
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Worton, Stanley Ivan, Miami Beach (Duke U. 1960)
York, Woody Neil, Tampa (Tulane U. 1958)
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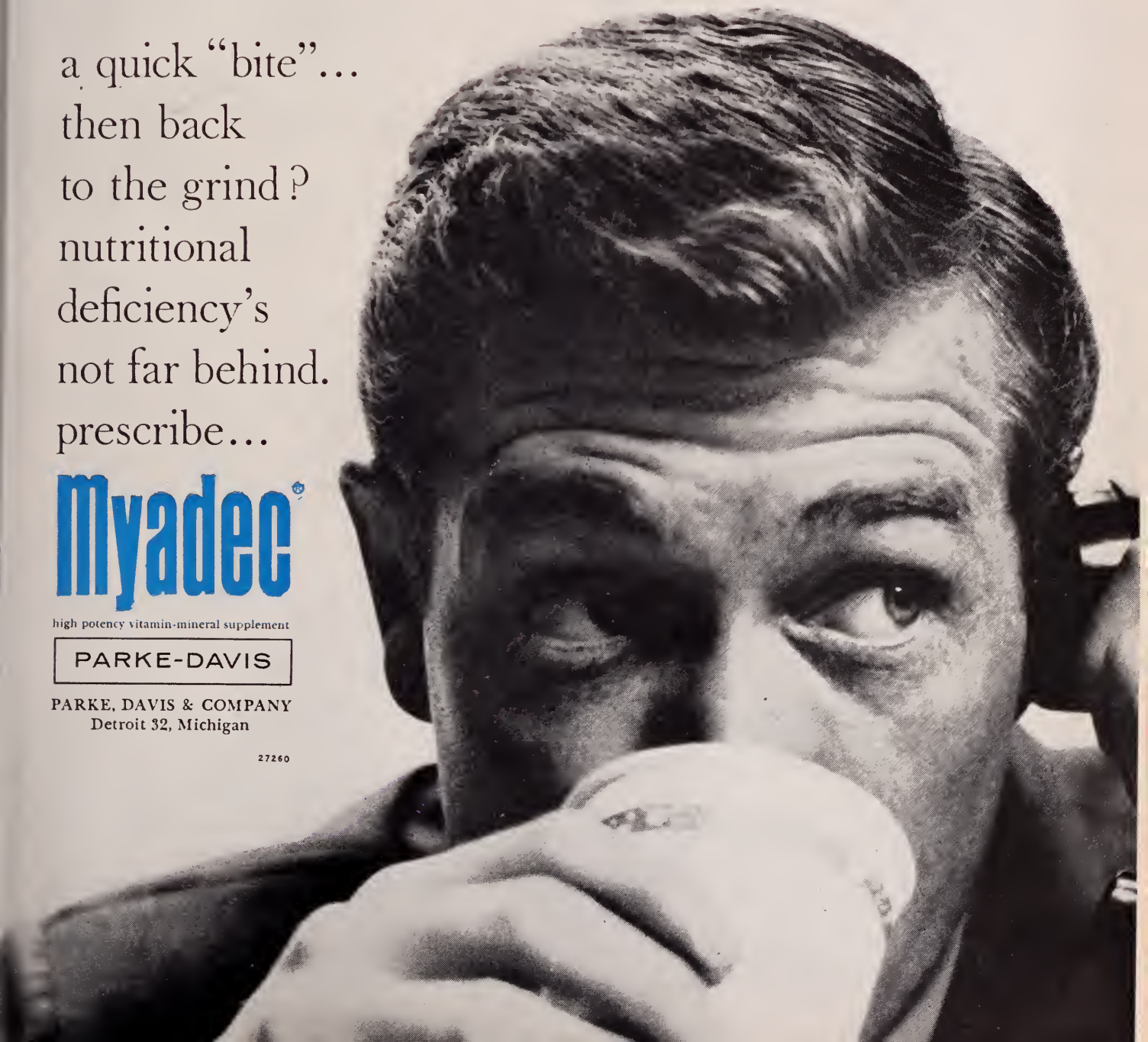
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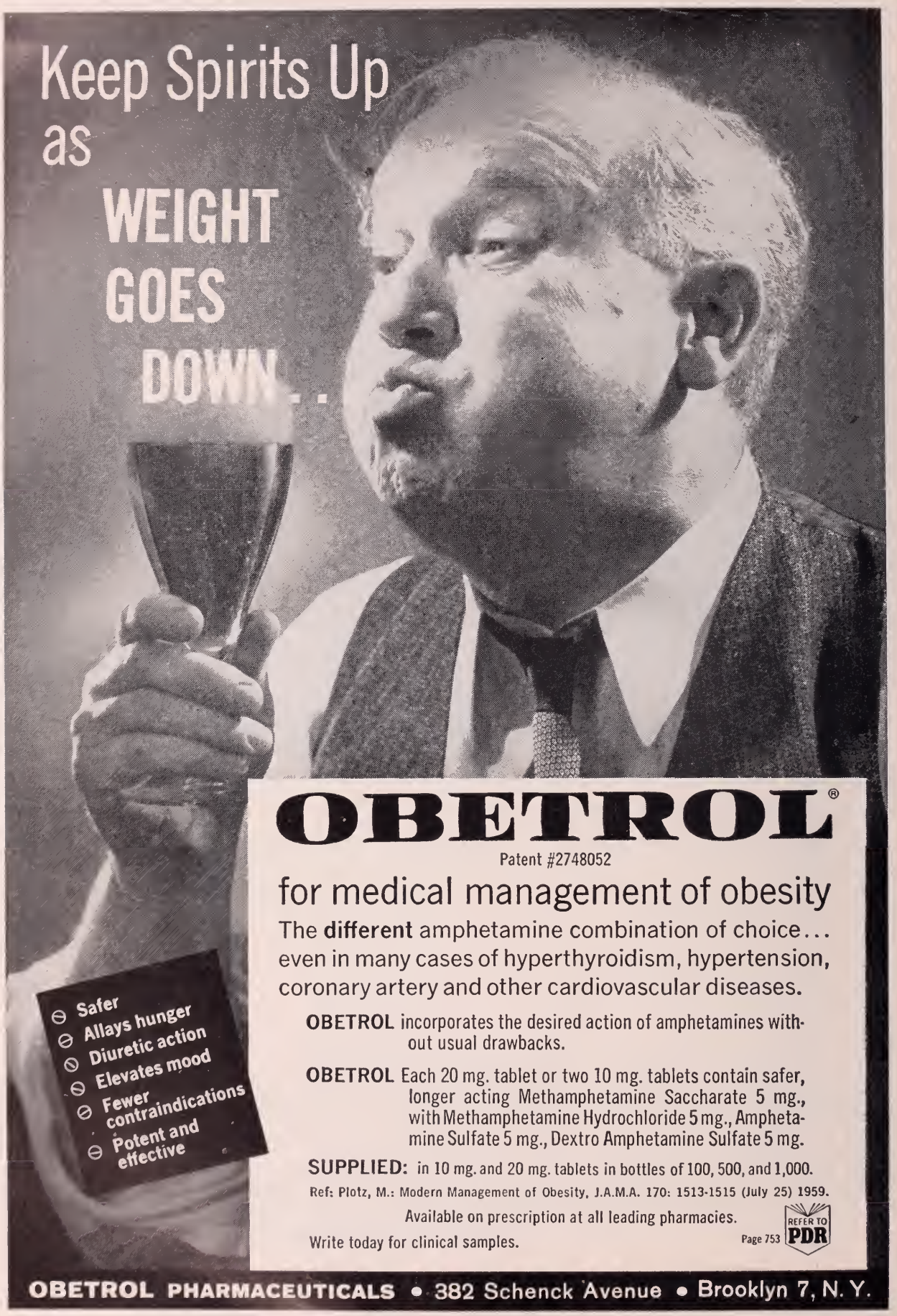
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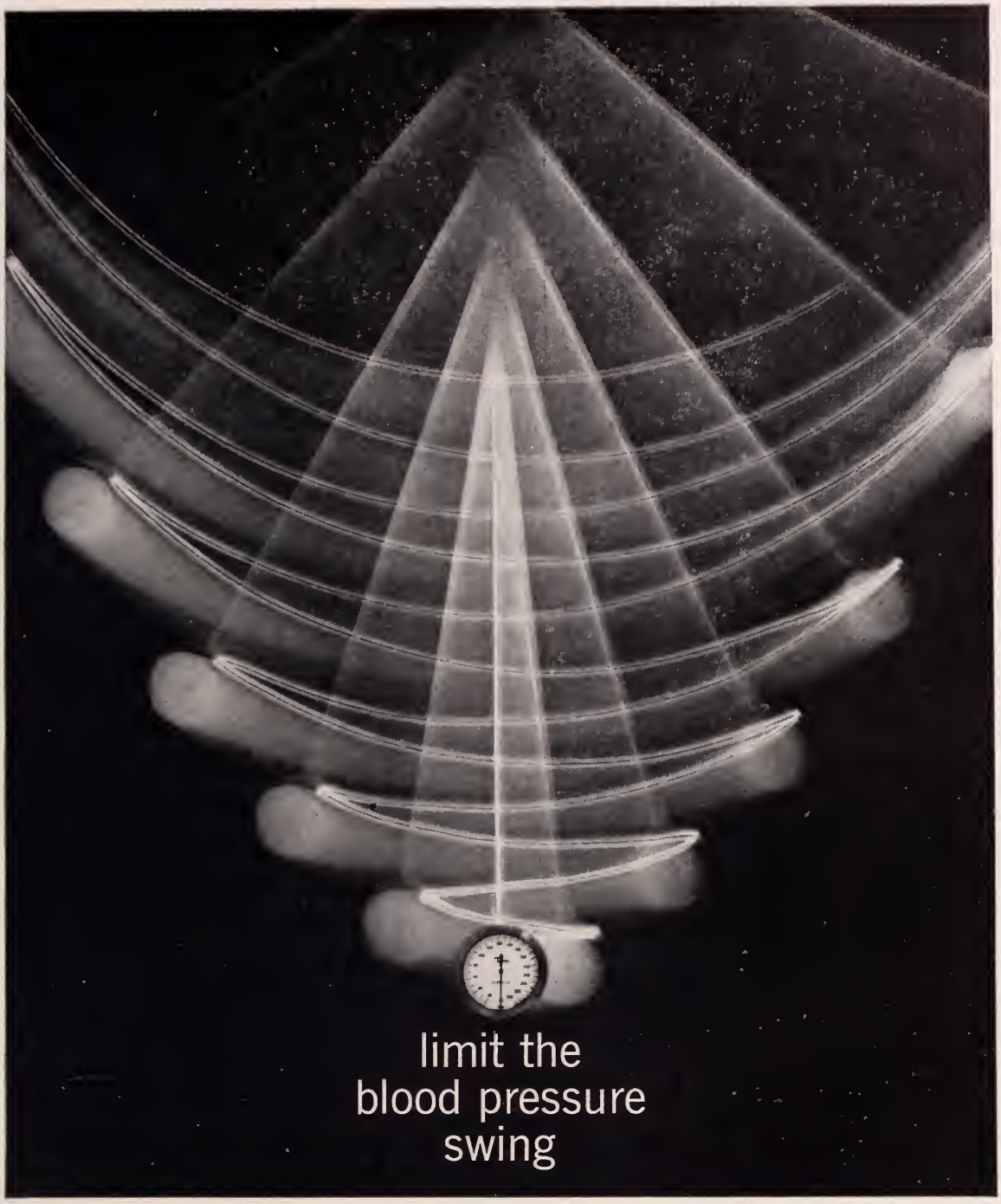
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BIRTHS AND DEATHS

Births

Dr. and Mrs. Joseph D. Foley of Jacksonville announce the birth of a daughter, Debbie Lynn, on July 5, 1960.

Deaths — Members

Copeland, Silas Morgan, Jacksonville	August 20, 1960
Colley, Sanford C., Tavares	June 29, 1960
Limbaugh, Louis, Jacksonville	August 1, 1960
Stansbury, Thomas C. Jr., Sarasota	May 3, 1960
Shaw, Wilfred McLaurin, Jacksonville	July 23, 1960

WOMAN'S AUXILIARY

Fall Conference and Board Meeting
Surf and Sand Hotel
Lido Beach, Sarasota
October 18-19, 1960

A cordial invitation to the Fall Conference is extended to all Auxiliary members who are interested. The local group is making plans that will insure FUN, FELLOWSHIP, AND FRIENDLY RELATIONS as well as INFORMATION AND INSPIRATION. The Conference opens with an informal coffee at 10 a.m. on Tuesday, October 18. Exhibits on all phases of Auxiliary work will be open at this time and Committee Chairmen will welcome your questions as well as your ideas and suggestions. I shall look forward to seeing you.

Mrs. John M. Butcher

Mama Due Real Vacation

At this time of year, it behooves us to give consideration to vacations for the female of the species. Frequently the mother and children take a "vacation" once a year or less. This possibly consists of packing, crowding into the car, driv-

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ing like mad to the beach or the mountains, to live there in less than ideal housing and perform the same services that have been done for the rest of the year, plus the inconvenience of having inadequate facilities. This seems less than a real vacation for this tired mother ! !

It it amazing the number of women who never spend a night under a different roof from their child or children except for the times that they are in the hospital in the process of producing further children. It is my belief that it is utterly impossible to live on a higher mental plane than that of the youngest child if one is with that child or children continuously.

Years of "sameness" leaves little wonder that so many women are "tired mothers" until eventually they turn into "tired grandmothers." I feel strongly that adults need to live as adults with some degree of predictable regularity. It isn't necessary to get fancy and throw out of kilter a delicately balanced budget, but the prime requisite is to get away from the children and live as adults. This could be accomplished by even going to Kissimmee or Sanford and sitting in a rocking chair or going fishing. At least this would be different from the ordinary routine living day after day, week after week and year after year.

Of course, one must be satisfied that the children are taken care of adequately. There are some parents who have the unmitigated gall to assume that they are the only ones who can care for their children adequately, overlooking the fact that millions upon millions of children were reared very successfully by others. Self-reliance of the children would be enhanced if every waking breath weren't "mama," "mama," "mama," and becoming entirely dependent upon the same individual for everything. There is little question that a successful marriage would be greatly augmented if the husband and wife took these predictably regular times to live as two adults.

Robert L. Tolle, M.D.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Boling, Davis S., Tampa
Egolf, Robert L., Key West

(Continued on page 485)



"Sometimes, when I have a running nose, I'd like to clear it with TRIAMINIC® just to check out that systemic absorption business.

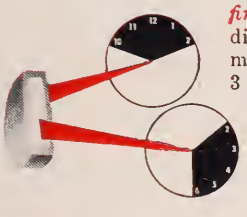
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Each timed-release Triaminic Juvelet® provides:
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Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
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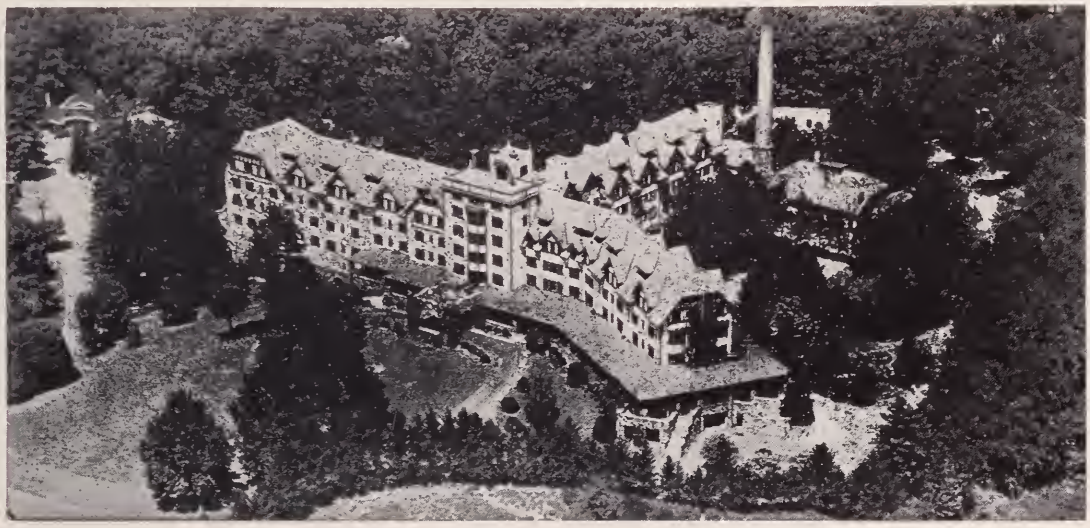
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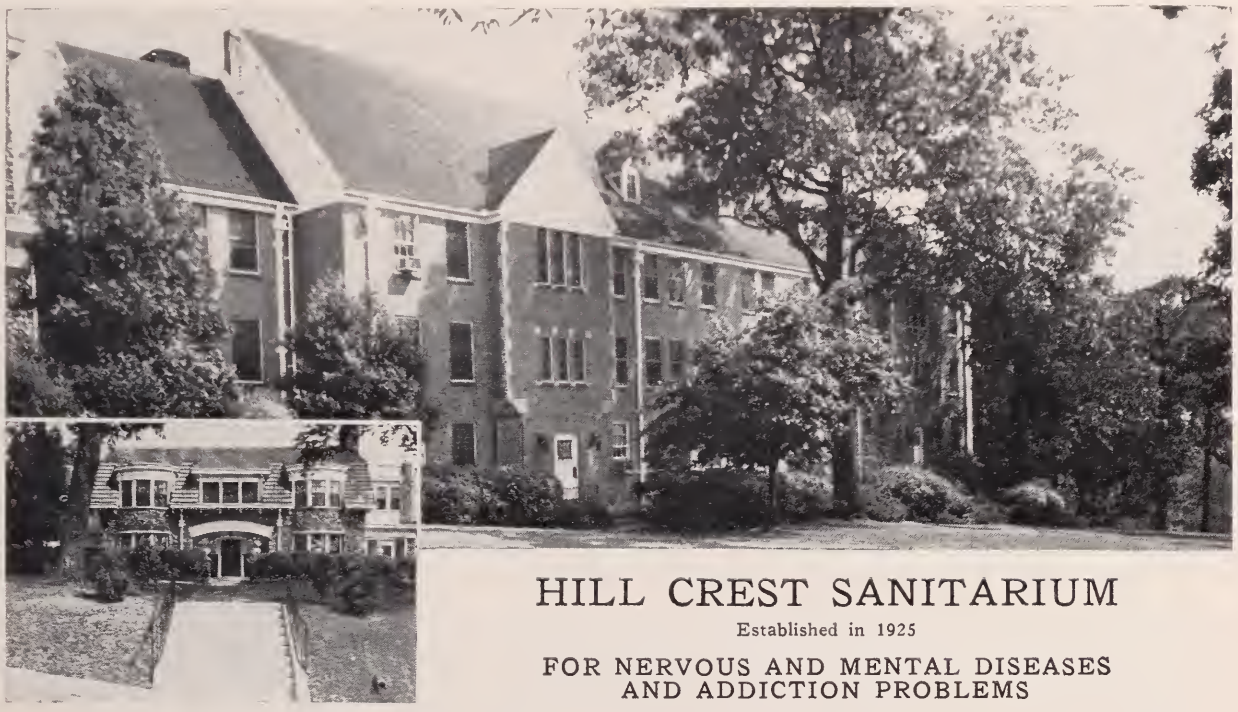
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Dental Society, State	Wallace Mayo, Pensacola	Munroe Farber, Vero Beach	Miami Beach, May 21-24, '61
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Hospital Association	Arthur L. Bailey, Orlando	J. F. Monahan Jr., Orlando	Miami, Nov. 30-Dec. 2, '60
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S. E. States Cancer Seminar			Orlando, Nov. 16-18, '60
S. E. Hospital Conference	Gene Kidd, Nashville, Tenn	G. C. Long Jr., Montgomery, Ala.	Memphis, April 19-21, '61
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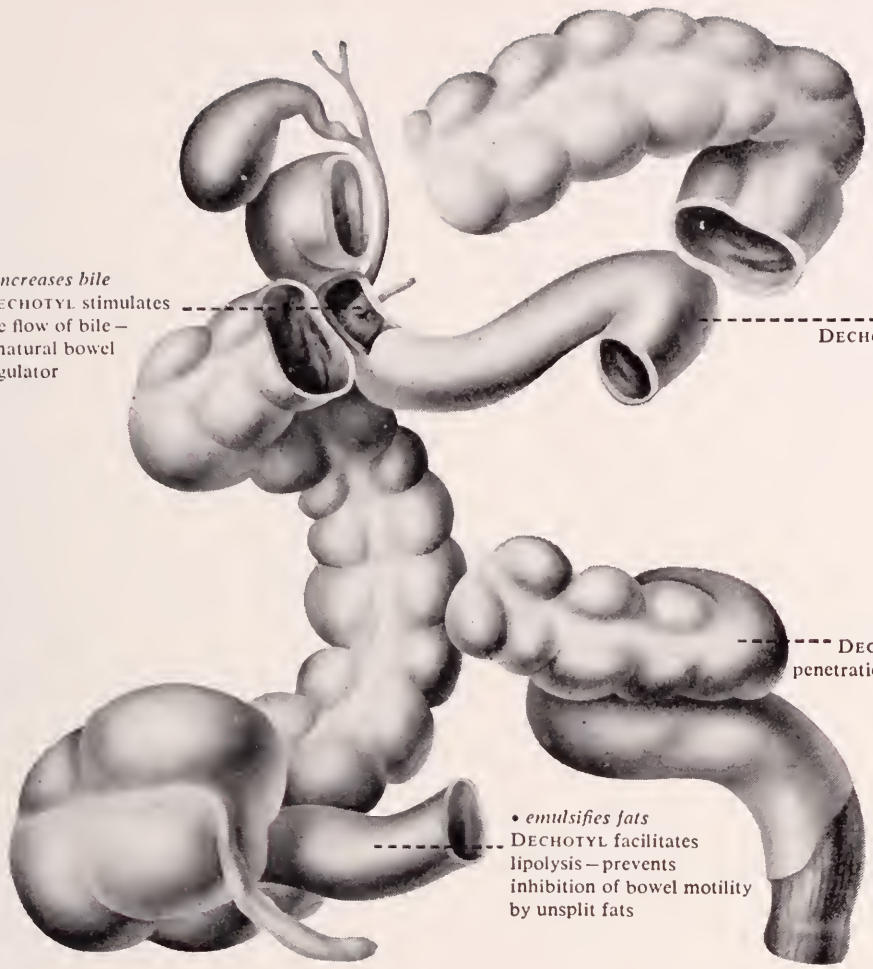
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Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	37	267
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
** Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	124	1036
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	357
Clay	Marcus B. Bergh, Orange Park	John M. Malone, Green Cove Springs			10
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	120
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	260
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References: (1) Goodier, T. E. W., & Parry, W. R.: *Lancet* **1**:356, 1959. (2) Modarress, Y.; Ryan, R. J., & Francis, Sr. C.: *J. M. Soc. New Jersey* **57**:168, 1960. (3) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (4) Rebhan, A. W., & Edwards, H. E.: *Canad. M.A.J.* 82:513, 1960. (5) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (6) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* **8**:324, 1959. (7) Berle, B. B., *et al.*: *New York J. Med.* **59**:2383, 1959. (8) Fisher, M. W.: *Arch. Int. Med.* **105**:413, 1960.

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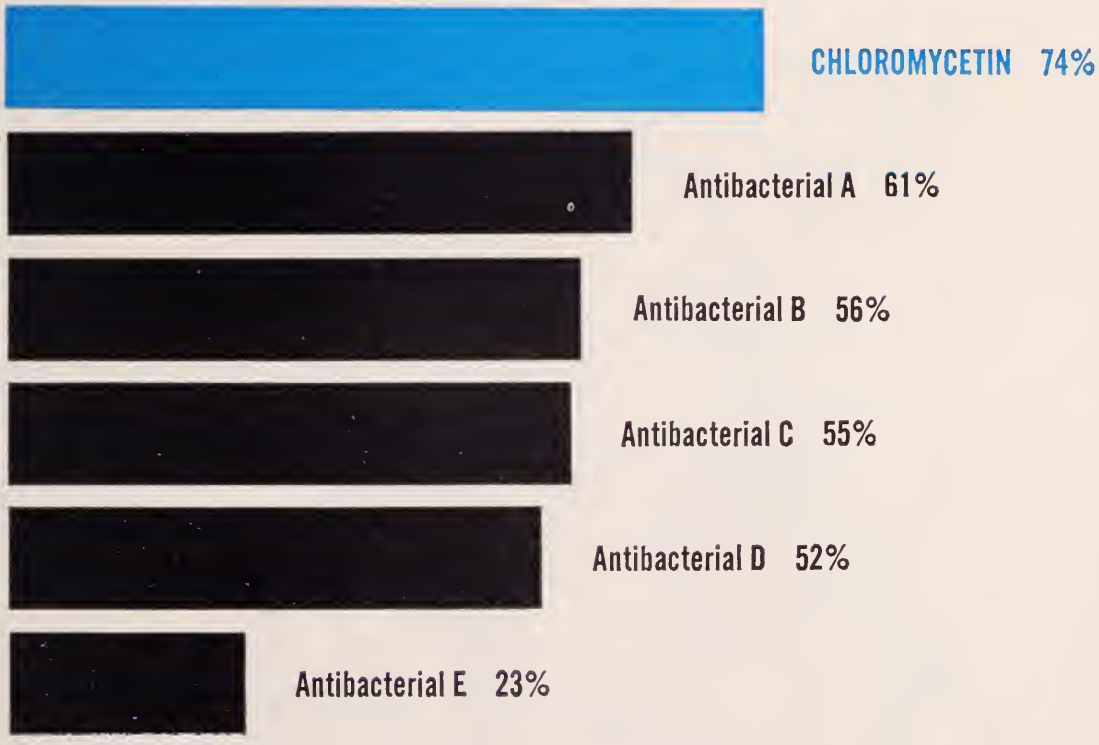
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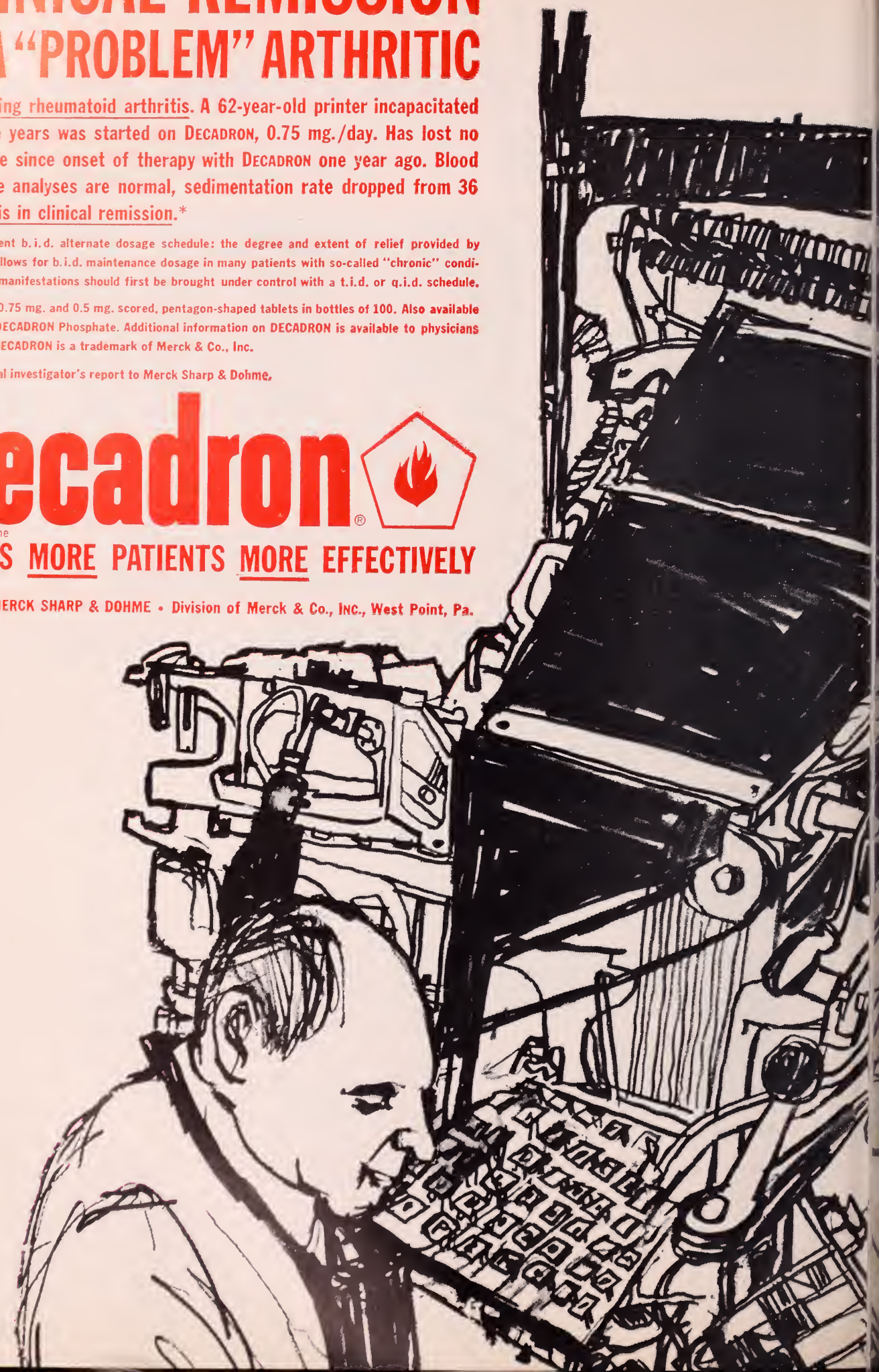
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VOLUME XLVII, No. 5

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• November, 1960

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

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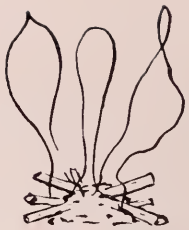
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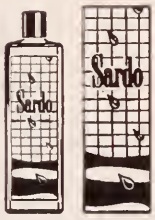
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1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

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Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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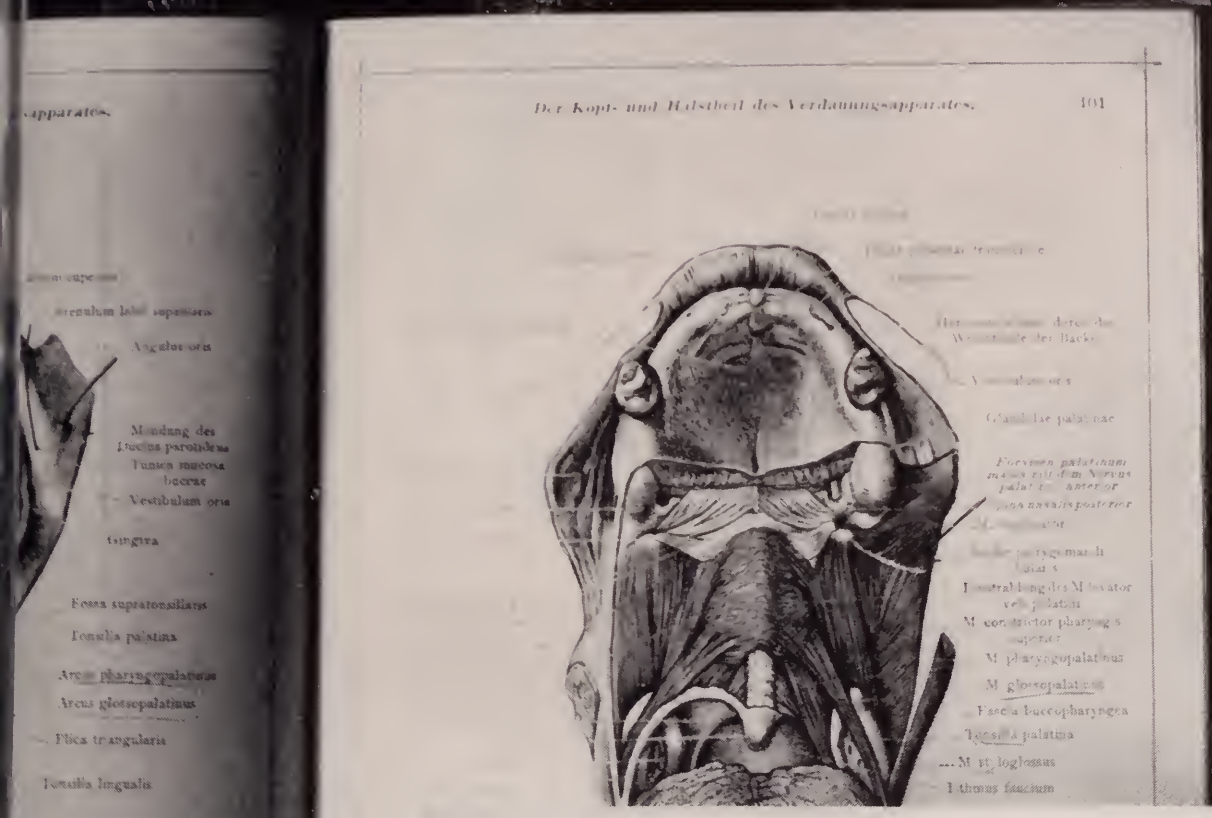
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1. Stephens, V. C., *et al.:* J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.:* Antibiotics Annual, p. 893, 1959-1960.
3. Reichelderfer, T. E., *et al.:* Antibiotics Annual, p. 899, 1959-1960.
4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

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THE JOURNAL
OF THE
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Volume XLVII, 5, November, 1960

Parathion Poisoning and Treatment

WARREN LINDAU, M.D.
AND
ROGELIO G. MARCIAL, M.D.
CORAL GABLES

Parathion, a very effective insecticide that has been widely used in recent years, has been a tremendous boon to the farmer. Its widespread use is attested to by the worldwide distribution of reports of human fatalities—Australia,[1] Egypt,[2] Brazil,[3] the United States and other countries.

Obviously, it has been forgotten that this compound is the result of a search for chemical warfare agents by Germany during World War II and that closely related compounds are the "nerve gases" that have been mentioned in the medical literature[4] and newspapers.[5] The end result is essentially acetylcholine poisoning (that is, intense parasympathetic system activity). The characteristic clinical manifestations are an outpouring of the body fluids—profuse salivation, sweating, diarrhea and pulmonary edema.

Between March 1957 and March 1960 we saw 12 cases of Parathion poisoning. Ten of these were classical, and promptly recognized and treated. Of the two atypical cases, one was correctly diagnosed after several hours. The diagnosis in the other was made at autopsy by the medical examiner.

We will present a typical case, then the two diagnostic problems:

Report of Case

Case 1.—A 52 year old Negro farm laborer had been dusting with Parathion for five hours prior to the onset of his illness. Two hours before his admission to the hospital, restlessness, anxiety, profuse perspiration and excessive salivation developed. He became rapidly worse and was admitted in a stuporous condition.

Physical examination on admission revealed a somewhat comatose, restless patient in acute respiratory distress who responded by mumbling and groaning. The skin of the upper extremities and trunk was covered with a fine, whitish powder. Profuse diaphoresis and excessive salivation were observed. The pupils were pinpoint. There was generalized muscular twitching as well as gross tremors in all extremities. Spasticity was also noted in all extremities. The heart and lungs were essentially normal.

On admission, oxygen therapy was instituted. The powder that was sticking to the skin was washed off. Large doses of atropine, ranging from 1/75 grain to 1/30 grain, were administered both intravenously and subcutaneously, alternately or simultaneously, every five to 15 minutes for the first six hours. Thereafter, the dosage as well as the frequency of administration was reduced in accordance with the response of the patient. One hour after therapy was started, the patient started to become alert and gradually became able to respond intelligibly. The pupils started to dilate on the tenth hour of intensive atropine therapy. The patient gradually and steadily improved and was discharged in good general condition.

Serum cholinesterase activity, taken on admission and reported when the patient was convalescing, was about 3 per cent of the control value.

Case 2.—The second case presented with the manifestation of acute pulmonary edema and was initially treated as a cardiac problem.

A 59 year old Negro man came to the emergency room in acute respiratory distress. No one accompanied him, and he was too ill and confused to give a detailed history.

Physical examination on admission revealed a confused, apprehensive and acutely dyspneic patient with bubbling respirations and foaming at the mouth and nose. The temperature was 96.8 F., the pulse rate 62 per minute, the respiratory rate 36 per minute and the blood pressure 160/80 mm. Hg. Pertinent findings were confined to the lungs where, even without the stethoscope, crackling rales were audible. By auscultation, coarse, crackling and bubbling rales were heard all over the chest, posteriorly and anteriorly. The heart was within normal limits in regard to size. The skin was covered with cold, clammy perspiration. The pants of the patient were full of soft, brown stools. The electrocardiogram was interpreted as indicating sinus tachycardia with occasional premature ventricular contractions and coronary insufficiency (digitalis effect?). A roentgenogram of the chest on admission revealed elevation of the diaphragm on the left side with narrowing of the interspaces.

A diagnosis of pulmonary edema (of cardiac origin) was made, and the patient was treated with oxygen, morphine, atropine, Cedilanid and diuretics. While he was in the emergency room there was transient improvement of the respiratory distress (presumably due to the effect

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of the atropine). About two hours after admission he started to drool and the sweating became profuse. The blood pressure dropped to 80/60 mm. Hg., and he became more dyspneic.

At this time, several hours after admission, his family came to the hospital, and it was learned that he was a farmer. He had been spraying Parathion without precautions for two weeks, including the morning of his admission. The patient had been well until about two weeks prior to admission when he started to have persistent headaches. About three or four hours prior to admission, he began complaining of fainting spells and nausea. He vomited twice at home. By this time, he was also complaining of a feeling of thickness of the tongue. About two hours prior to admission, marked dyspnea developed, and his respirations became bubbling in character.

Large doses of atropine were then administered. The first dose was 1/100 grain intravenously. Subsequent doses ranged from 1/75 grain to 1/30 grain subcutaneously. He responded well.

Cholinesterase activity determined six days after admission was 25 units (normal 50 to 100 units).

Case 3.—In this case, the patient was admitted to the hospital in a coma, and presented the house staff with the problem of coma of unknown etiology.

A 55 year old Negro farm laborer came home from work complaining of general body weakness and dizziness (about six hours prior to admission). At the same time, there was profuse sweating. Shortly before admission, the patient became aphasic and weakness developed in all extremities. This was followed by coma.

Physical examination on admission revealed a comatose patient who was perspiring profusely. The blood pressure was 204/98 mm. Hg. The pupils were pinpoint. The right angle of the mouth was drawn to one side. Sibilant and moist coarse rales were heard all over both lung fields. The deep tendon reflexes were hypoactive and the Babinski sign was slightly positive on the left side.

Admitting diagnoses of "cerebrovascular accident" and hypertensive encephalopathy were considered.

The patient was given intramuscularly one dose of 2.5 mg. of reserpine. Supportive therapy was then instituted. About five hours after admission Cheyne-Stokes respiration developed and he expired.

This case was subsequently investigated by the Medical Examiner, Dr. Joseph Davis. Postmortem examination revealed pulmonary edema. Dr. Davis then questioned the widow as to what the patient had been doing when he became ill. She revealed that he had been dusting collard greens with "2-5" (2 per cent Parathion and 5 per cent DDT).

Determination of cholinesterase activity of the blood on postmortem examination revealed zero activity.

Discussion

While Parathion comes in bags that are very well labeled with an excellent description of the danger, most of our patients were impoverished Negro farmers and there is good reason to suspect that most of them could not read. There is no doubt, therefore, that deaths from this potent chemical will continue until the legislature or responsible administrators require licensing and examination to handle this deadly poison. In the meantime, we must be conscious of this entity and be prepared to treat it adequately.

As in all of medicine, the diagnosis is dependent upon a good history. As we mentioned in the introduction, the diagnosis should be considered when there is an outpouring of body fluids from all orifices and surfaces—salivation, pulmonary edema, sweating and diarrhea. This may, however, present with other manifestations—goose flesh,[6] neurological manifestations, or in other guises.

The diagnosis must be based upon the clinical findings. Cholinesterase determination is a specific test, but it is time-consuming and usually the pa-

Parathion Poisoning Cases Treated at Kendall Hospital,* Miami, Between March 1957 and March 1960

PATIENTS	RACE	OCCUPATION	DATE OF ADMISSION
1	Negro	Farm Laborer	Mar. 15, 1957
2	Negro	Farm Laborer	Mar. 15, 1957
3	Negro	Farm Laborer	Sept. 6, 1958
4	White	Lawn Spray Man	Sept. 10, 1958**
5	Negro	Farm Laborer	Nov. 5, 1958
6	White	Farm Laborer	Nov. 13, 1958
7	Negro	Farm Laborer	Jan. 22, 1959
8	Negro	Farm Laborer	July 21, 1959
9	Negro	Farm Laborer	Aug. 3, 1959
10	Negro	Farm Laborer	Aug. 12, 1959
11	Negro	Gardener	Aug. 14, 1959
12	Negro	Tractor Driver	Mar. 25, 1960

*Unit 2, Metropolitan Dade County Department of Hospitals.
**Hospitalized at Jackson Memorial Hospital (Unit 1, Metropolitan Dade County, Department of Hospitals).

tient will be dead or out of danger by the time it is completed.

Fortunately, a specific drug is available—atropine. It, like all medications, must be given in adequate dose. We now think that the seriously ill patient should be given 1/30 grain intravenously every 15 minutes until his condition has appreciably improved. Then smaller doses can be given subcutaneously.

At first one has qualms about giving such large doses of atropine. After a little experience, however, one realizes that in these patients with intense activity of the parasympathetic system it is almost impossible to give too much atropine. One will be slightly disturbed by the thought that he may be giving 1/30 grain of atropine intravenously every 15 minutes to a patient who has not received Parathion (that is, when one is uncertain of the diagnosis). It is reassuring to read that 1/6 grain (10 mg.) has been given intravenously to Normal persons without endangering their life.[6]

Summary

Twelve cases of Parathion poisoning were seen in Kendall Hospital between 1957 and 1960. Ten of these were promptly diagnosed and treated. One case presented a clinical picture strongly suggesting acute pulmonary edema of cardiac origin but the correct diagnosis was made after a delay of several hours. The only fatality presented the problem of coma of unknown etiology and was misdiagnosed as an intracranial lesion. In areas where Parathion is used, it should be considered in the differential diagnosis of acute pulmonary edema and coma.

Atropine is specific for Parathion toxicity, but must be used in large doses. In the treatment of seriously ill patients, 1/30 grain intravenously every 15 minutes is suggested.

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Discussion

Dr. Jere W. Annis, Lakeland: The discussion of this subject is most timely, since the use of Parathion and other phosphate ester insecticides is becoming more widespread. Except for their toxic properties to human beings, they approach the ideal insecticide. In our area in the center of the state, we have had occasion to have a moderate amount of experience with cases of poisoning from this chemical during the past 10 years. In our area, at least, the incidence of poisonings was much higher about five to 10 years ago than it is at the present time, although recently I have seen one of the most serious nonfatal cases that I have seen at any time.

I am sure that the decreased incidence of severe poisonings has been due to the fact that those persons who ordinarily employ the chemical have either become much more cautious in its use, insisting upon certain preventive measures amongst the personnel handling it, or have abandoned the use of the insecticide altogether, as being too dangerous. This latter is certainly the best for those persons with a limited mentality, and especially with those who are unable to read. Several large scale operations have proved that the chemical may be safely used in high concentrations, large amounts and over long periods of time, in a very successful manner, by groups of well trained personnel using proper precautions and subjecting themselves to routine cholinesterase determinations. Another factor in the reduced number of cases is the use of the 15 per cent oil solution which may be mixed one pint to 1,000 gallons of H_2O, in place of the wettable powder which of course was much more apt to be inhaled or ingested.

I have enjoyed Dr. Lindau's and Dr. Marcial's paper and think that they have adequately covered the subject. I would emphasize, however, several things that have been brought out in their discussion. The first relates to the pharmacology and toxicology of this drug, and the many questions that remain unanswered about its exact pharmacological properties—particularly its toxic ones. At the present time it would seem that the only *important* action of Parathion is its ability to inhibit the enzyme acetylcholine esterase which catalyzes the hydrolysis of acetylcholine. We know so little about the chemistry and physiology of this complex metabolism, however, that we can only presume that the pathology involved in Parathion poisoning is the accumulation of acetylcholine and consequent parasympathetic stimulation. The result, then, is the same as is seen with any parasympathomimetic drug.

My personal opinion is—and I expressed this some seven years ago in an article in the Journal of the American Medical Association on this subject— that additional mechanisms are involved. To date, however, no one has, to the best of my knowledge, proved this, and we must still assume that the anticholinesterase activity is the chief, if not the only, mechanism by which these compounds—the phosphate esters—exert their toxic effect. I say this with trepidation because the medical literature has been so filled with papers upon this subject in all languages during the past six or seven years. I reluctantly admit my inadequacy as a discussant, since I have not carefully covered this mass of material and may be unaware of recent work that has thrown a new light on the subject. My only excuse is that the bulk of this work is in a foreign tongue, and of course that is no excuse at all. At present I am slowly working my way through an 80 page review in German which should bring things fairly well up to date.

Insofar as therapy itself is concerned, it has already been pointed out that atropine is a specific, or at least is *listed* as a specific. As my experience with this condition grows, I am convinced that huge amounts of atropine must be administered; and at the present time we rarely start with less than 1/10 of a grain intravenously, and continue with 1/10 or 1/25 of a grain intramuscularly or intravenously, as already outlined by the authors.

We must remember that we are dealing with a parasympathetic blocking agent, however, rather than a stimulant drug of any sort; and consequently, its effectiveness, even in large amounts, may be relatively slight. It is my own impression that it would be virtually impossible with any dosage to produce signs of atropine poisoning in these patients in the early stages of their toxicity, and although I have never given it, I believe that, undoubtedly,

a half-grain or more of atropine could be given with little or no effect. As the patient improves, the drug—that is, atropine—seems to become more effective; but I am not sure how much of the actual improvement is due to the atropine itself. Perhaps it simply keeps the condition from becoming worse.

In at least one severe case of poisoning in which coma persisted for 84 hours, we have shown that rather marked and dramatic changes in the blood chemistry occurred, and that the pH was drastically lowered. It was this case which led us to the decision that the use of whole blood might be advisable, and since that time, in severe cases, I have thought that it is perhaps the most valuable adjunct that we have. Certainly it will furnish some cholinesterase activity in the circulation of those critically poisoned patients whose cholinesterase activity in the red cells is so low that it cannot be accurately determined, and in two or three instances since that time it has seemed to me to be a life-saving procedure. This, of course, is difficult of proof. We shall continue to use it, however, and in a very severe case, if plethora already existed, I would not hesitate to perform a phlebotomy and then transfuse, in order to obtain an adequate measure of circulating cholinesterase, as well as to change back in the direction of normal, those blood chemistries which may be deranged.

It was interesting that, in our most severe case of poisoning in which the patient survived, our attention was directed to the changes in blood chemistry by the extremely hot canister on the oxygen machine via which the patient was receiving artificial respiration. When this was replaced with a new canister of soda-lime, it, too, became too hot to touch in a matter of about 15 minutes, indicating the rather low pH of the expired air. This patient's blood pH, incidentally, at this time was 6.76.

It has been our impression, in the past 10 years, during which time we have had experience with perhaps 30 to 40 cases of Parathion poisoning of various degrees, that ingestion of the material—particularly the dust—is the most common cause of severe poisoning. It has been almost unknown in our experience to see cases in which the toxicity is even moderately severe, that resulted solely from the use of contact with the spray itself in the recommended dilutions, in an open field. There have been minor exceptions in the instances in which the person on the truck doing the spraying became literally drenched with the solution, due to peculiar wind conditions and other factors. For the most part, however, in our cases of serious poisoning the patient had either mixed the solution or in some way handled the concentrate or the dust, and we have presumed in many instances that actual ingestion of the powder had taken place through smoking, eating, and other means, and through improper cleansing precautions. With this in mind we have, on several occasions, taken advantage of gastric lavage, in order to prevent further absorption. Dr. Lindau and Dr. Marcial have already pointed out the importance of scrubbing the patient's skin adequately, in order to prevent further uptake of the material.

We have seen a few deaths from this poison. The patients were all severely poisoned, with rather massive dosage, and expired shortly after reaching the hospital. Certainly the importance of prompt treatment is great. Our dosage of atropine has continued to increase annually.

We still think that there is a necessity for further research on this subject as to the exact mechanism and mode of action of the compound. It presents a very real problem which is of particular interest to the internist, and which must be satisfactorily solved, since the agent itself is an extremely valuable one from a commercial standpoint, and if handled properly, can be used with complete safety.

Again, I think that we are indebted to the authors for a most concise and instructive consideration of this timely subject.

DR. ROBERT A. DOUGLAS, HOMESTEAD: I read Dr. Lindau's and Dr. Marcial's paper on Parathion poisoning with much interest and I would like to say at the beginning that I agree with all that has been said. It corresponds with what we have found to be true in my locality.

In my work as Deputy Medical Examiner in the office of Dade County Medical Examiner we have had six deaths due to Parathion poisoning. I thought it might be interesting, as well as informative, to mention these six deaths and give some of the precautions that we, as physicians, might remember and pass on to our patients, in the use of Parathion as an insecticide.

The six deaths we had in Dade County in the past 18 months due to Parathion poisoning break down into the following categories:

1. Two suicides.
2. Two farm workers, who died as a result of overexposure to Parathion.
3. Two small Negro children who died after ingesting different amounts of Parathion powder and also liquid Parathion insecticide.

Of the two suicides, one was found dead in a chair in his front yard, and the other was an alcoholic who, after a family squabble, ran to the garage and drank a large amount of Parathion insecticide and died some 15 minutes later.

Of the two farm workers, the case of one was reported in Dr. Lindau's and Dr. Marcial's paper. The other one had been working with insecticides for some 12 years and with Parathion for the past 12 months. He gradually became intoxicated with Parathion and died before he could be taken to the hospital, although I might say that the diagnosis was missed by the physician who attended him at his home.

We have had no homicides in Dade County as yet from Parathion poisoning and we hope we never shall.

Of the two children, one child got into a bag of dust containing 2 per cent Parathion and took a mouthful of it. This child was taken to the Children's Hospital and became moribund before the diagnosis was made. The other child ingested an unknown quantity of the liquid insecticide, and the diagnosis was missed because of the fact that the child also had leaves from a poisonous shrub in his hand. By the time the mystery could be solved as to what he had ingested, the child had expired.

There are some precautions that I would like to bring to the attention of those assembled. They are these:

1. In children when there is any question as to the nature of the material ingested in poisoning, we have found that it is most expedient, instead of waiting for the family to come in, either to go to the scene of the poisoning or call by phone to the Law Enforcement officers who brought the child in, or to the parents of the child, to find out as quickly as possible what the child has taken. If it is an unknown powder, then we suggest that they bring it in to the hospital immediately. If this is done, in a great many cases unnecessary delay can be avoided.

2. Another precaution is, as in the case of adults, if there is any question whether the child or adult has been poisoned by Parathion, that he be treated as having been poisoned because atropine poisoning is a much less severe and much more easily treated condition than Parathion poisoning.

3. A third precaution that should be stressed in the use of the dust or the liquid spray around the house is that the person using the spray be very meticulous in washing his hands and face and other parts of his body that may have come in contact with the poison after he finishes. He should be careful that he sprays down wind so that the spray does not get into his face. He should be careful that he does not contaminate food particles or toys that children might pick up and put into their mouths.

As far as farmers are concerned, there are several precautions that might be taken:

1. Workers handling Parathion insecticides, either in dust or liquid form, should have periodic blood checks to make certain that the level of the poison is not reaching a dangerous level. There is a screening technique that can be done with very little loss of time as far as workers

are concerned, and it is very inexpensive and is most worth while. This is most important in this particular type of poisoning because there is an accumulated effect, and even if the worker does not handle excessive amounts of the poison, the mere fact that he handles these insecticides day after day can produce, over a period of time, a lethal intoxication.

2. Another precaution is that the farmers should make certain that the user of these insecticides understands the hazard, and the precautions he should take, realizing full well that many of these workers cannot read sufficiently well to be able to read the labels on the bags or cans.

A person who has, through blood examination, been found to have a high intoxication level, should be taken away from the poison and remain away until his blood test shows that his level has returned to normal, which may be some weeks.

The last precaution that I should like to speak of is that we, as physicians, be ever aware of the unscrupulous people who are trying to produce Parathion sprays and dusting powders to be used in the household on pets and roaches and the like. This is a very real hazard. We have had a case here in Florida that was taken all the way to the Supreme Court, where a company was trying to get a license to make a 1 per cent Parathion flea powder, which we know is a dangerous concentration of Parathion and would have been a very real hazard in our Florida households. I am happy to report that this company was not granted the license to produce this flea powder.

These are some of the things we, as physicians, should be aware of and look for. In closing, I would like to say the most important thing is that as physicians, we should think of Parathion poisoning when we have some adult or child who comes in with the symptoms as presented by Dr. Lindau and Dr. Marcial in their paper, and that a well informed medical population, as well as lay population, can greatly reduce the hazards, as we now know them today, of Parathion poisoning.

Pregnancy Complicated by Subacute Bacterial Endocarditis

Report of a Case

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The purpose of this report is to review a case in which a severe cardiac complication occurred in pregnancy. Many physicians practicing in Southern regions seldom encounter patients who have rheumatic fever with valvular defects, and the problem does not become severe. It is, however, the custom of those who care for patients with these abnormalities to treat them with prophylactic penicillin during pregnancy to prevent a recurrence of the rheumatic fever. If the more severe complication of subacute bacterial endocarditis occurs, this prophylactic penicillin may not only not prevent it, but may make the organism causing the endocarditis more resistant to the usual forms of therapy.

Report of Case

A 27 year old woman, Gravida 2, Para 0, whose last normal menstrual period was June 22, 1958, making her expected date of confinement March 29, 1959, was admitted to the hospital on Jan. 30, 1959 in active labor, with contractions occurring every six minutes, membranes intact and a bloody show. Her total gain in weight had been 9 pounds, and there had been no edema. Urine specimens had been consistently negative for sugar and albumin. During the antepartum course, the patient had been taking prophylactic penicillin tablets as a preventive against the recurrence of rheumatic fever.

Obstetrical History: Her first pregnancy occurred in 1958. After three months of gestation, the patient passed a conception which resembled hydatid degeneration, and pathologic examination confirmed the hydatidiform mole. The Friedman test gave negative results at the six week postpartum examination.

Menstrual History: With the onset at the age of 13, menses occurred regularly every 28 to 30 days, lasting four to five days without cramps or clots.

Past History: The patient had rheumatic fever as a child. Otherwise, she experienced the usual childhood diseases without sequelae and no operations or injuries.

Physical Examination: The height was 5 feet 6 inches, the weight 122 pounds, the temperature 99 F., the pulse rate 104, respirations 16 and blood pressure 110/60 mm. Hg. The patient was a well developed, fairly well nourished, white woman in acute distress. Glasses with thick lenses were required to correst a severe myopia. The chest was clear to percussion and ascultation. The heart rate was 104 per minute and had remained at this level for the past month. There was a grade III systolic and a grade III diastolic murmur heard over the entire precordium, probably strongest at the apex of the heart. The uterus was enlarged to 26 cm. above the symphysis pubis. The fetal heart tones were good in the right lower quadrant of the abdomen. The cervix was 7 cm. dilated; the membranes were intact and bulging. The vertex was well applied to the lower uterine segment. The pelvis was of the gynecoid type. The bony pelvic measurements were: the conjugata diagonalis was not reached at 12 cm., and the conjugata vera was over 10 cm. The ischial spines were well spaced. The sacrosciatic notch admitted two fingers with ease. The coccyx did not project into the birth canal, and the bi-ischial diameter was greater than 9 cm.

Impression on Admission: (1) Pregnancy in labor at 34 weeks' gestation. (2) Chronic rheumatic heart disease with no evidence of congestive heart failure at this time.

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Laboratory Studies: On admission, examination of the blood showed a hemoglobin estimation of 13.1 Gm., red blood cell count of 4,490,000 and a hematocrit reading of 42 per cent. The white blood cell count was 8,650 with 66 per cent neutrophils, 31 per cent lymphocytes, 3 per cent monocytes and 2 per cent eosinophils. On urinalysis the urine was clear and amber in color with an acid reaction and a specific gravity of 1.016; it was negative for sugar, albumin and acetone. Microscopic examination showed an occasional red blood cell and three to four white cells per high power field. Serologic examination gave negative results, and the blood type was Rh positive.

During the remaining 56 days the patient had 12 complete blood counts, showing a progressive anemia down to a hematocrit level of 31 per cent and a hemoglobin estimation of 9.2 Gm. On February 7, the antistreptolysin O titer was 500 Todd units. The Lee White clotting time was 37 seconds and the prothrombin time 13 seconds. On March 5, the C reactive protein test gave positive results. The antistreptolysin O titer on February 23 was 500 Todd units. The protein-bound iodine on February 11 was 6.4 mcg. Eight blood cultures taken during the early weeks of February revealed no growth of bacteria.

Hospital Course: The patient was admitted to the labor room at 34 weeks' gestation in active labor and prepared for delivery. The labor was rapid, and the cervix was completely dilated after five hours in the hospital. Delivery was accomplished spontaneously over a median episiotomy using a saddle block anesthesia. The baby was a healthy girl weighing 5 pounds 1 ounce. She cried immediately. Loss of blood was minimal, and the immediate postpartum condition was good.

As soon as the patient had been admitted to the hospital, medical consultation was had to make sure that the stress of labor was not too much for her weakened heart. The cardiologist thought that her condition was good, with no evidence of congestive heart failure. During the next two hours, there developed some shortness of breath and mild rales at the bases of the lungs. She was digitalized as a prophylactic measure. The ensuing four days were completely uncomplicated, and the patient was almost discharged when it was noted that she had a spike of temperature to 100.2 F. The discharge was cancelled, and the patient was re-evaluated at that time. The tachycardia persisted, and there was a Roth spot in the right eye. The spleen was palpable, and it was suspected strongly that she had subacute bacterial endocarditis. She was given Sulfadiazine, aqueous penicillin, 10 million units every six hours, and streptomycin, 1 Gm. every 12 hours, and was watched for further developments. The temperature spiked daily for the next three days to 100.4 F. and thereafter remained normal. Three days after the last temperature elevation, petechiae were noted, and the Roth spot was reconfirmed in the right retina. For several weeks the patient continued to show evidence of petechiae and small emboli. On March 1, her thirtieth day of hospitalization, she had what was probably a small cerebral embolus with fleeting weakness and a positive Babinski sign on the right side. Three days later she had a massive subarachnoid hemorrhage and grossly bloody spinal fluid. She was very seriously ill and almost comatose, but gradually improved. The headaches lessened and the nuchal rigidity disappeared, and she gradually returned to her normal state.

Throughout the illness antibiotic therapy was continued. Following the first cerebral embolus, tetracycline was also given by mouth. She had been and remained afebrile on this massive antibiotic therapy. She was discharged in good condition on March 24, having received penicillin and streptomycin for six weeks. There was no residual paralysis except for a slight weakness of the medial rectus muscles from involvement of the third nerve.

Discharge Diagnosis: Pregnancy, uterine-delivered, a healthy baby girl weighing 5 pounds 1 ounce. Subacute bacterial endocarditis imposed on rheumatic heart disease with valvular involvement. Rupture of a mycotic aneurysm in the central nervous system leading to a cerebrovascular accident.

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The Use of Simple Roentgen Methods In Intervertebral Disk Syndrome Diagnosis

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Diagnostic procedures involve expenditures of time, of effort, of thought and of money. Some procedures are painful and some are not without danger. Davies[1] pointed out the necessity for restraint in the use of the valuable procedure of myelography by reporting the findings of follow-up examinations in 119 patients who had 125 myelograms. Even so simple a procedure as spinal puncture may according to Brailsford,[2] citing Billington, produce destructive lesions of the disk. Wood[3] in the introduction to the Atlas of Myelography stated that herniation of the intervertebral disk accounted for almost two thirds of the abnormal findings demonstrated by myelography at the Neurological Institute in New York in one year. The best procedures are those which are economical of time, of effort, of expense and of pain.

The intervertebral disks are present from the level of the second and third cervical to the fifth lumbar and first sacral vertebrae, where they are interposed between the adjacent bodies of the vertebrae. In the sacrum, the transverse ridges occupy their place. While the bodies of the sacral vertebrae are united at the periphery by bone, wide intervals are left centrally which are filled by fibrocartilage. Most frequently, the inferior portions of the sacrum are united more securely, that is, with more bone than the superior portions. The coccyx is a rudimentary vertebral structure.

The disks vary in size, shape and thickness in different portions of the spinal column and, according to Gray's Anatomy,[4] they constitute about one fourth the length of the vertebral column exclusive of the first two vertebrae. The cervical and lumbar regions have in proportion to their length a much greater amount of disk tissue than the thoracic region with the result that these portions of the spinal column possess greater pliancy and freedom of movement. In the cervical region, uncovertebral joints are found; in the thoracic region, the disks are joined laterally to the heads of those ribs that articulate with two vertebrae.

The centrum or body of each vertebra is formed around the primitive notochord (Sir Arthur Keith's evocator), but only between the centra where the intervertebral disks are formed does it persist in its primitive form and here it expands and forms a considerable part of the central mucoid core that each disk contains, the nucleus pulposus.

The size of the nucleus pulposus and its exact location vary in different parts of the spinal column. Comparatively, its size is greatest in the cervical and lumbar regions and less in the thoracic region. As a rule, in the cervical and lumbar regions it is situated at the junction of the middle and posterior thirds while in the dorsal region it is more anteriorly located. Schmorl's node formation is due to the protrusion of the nucleus pulposus into the spongiosa of a neighboring vertebral body.

Three essential structures make up the intervertebral disk, the nucleus pulposus described, the annulus fibrosus which is composed of a grouping of laminae of fibrous tissue and fibrocartilage, and the thin layers of hyaline cartilage which cover the adjacent vertebral bodies.

Simple Diagnostic Procedures

In an attempt to determine what relatively simple procedures are most helpful in the diagnosis of the syndrome of the intervertebral disk, the literature was searched and personal files were reviewed. The following salient facts emerge. Physiologically, the intervertebral disks are avascular and inert, and they are also elastic. From the point of view of pathology:

1. A common objective evidence is compression (manifested by diminution in vertical height of the vertebral interspace).
2. A common objective sign is subchrondral sclerosis.
3. A common objective sign is spur or osteophyte formation.



Fig. 1.—In 1945, operative intervention consisted of laminectomy with spinal fusion. The patient experienced no symptoms until she sustained a bus accident in August 1959. The lower portion of the back in the region of the site of the operation then felt hot as if there were bleeding and became painful. No radiation of the pain was noted at the onset, but subsequently (two days after the accident and now) pain and tenderness persist in the medial gluteal region, the hip region and the lower portion of the perineum. The most interesting roentgen finding here is calcification in the disk space between the fifth lumbar and first sacral vertebra.



Fig. 2.—A man, aged 55, complained of constant backache with pain radiating on occasion to the right and extending into and below the calf. The roentgenogram demonstrates the vacuum phenomenon, diminished vertical height of disk space, subchrondral sclerosis, and osteophyte formation, and incidentally, the regional vessels show arteriosclerosis. Roentgenogram by courtesy of Dr. Louis Raider, Mobile, Ala.

4. A less common objective sign is calcification.
5. A less common objective sign is the presence of a phantom nucleus pulposus or vacuum.
6. Not employed frequently enough is the distraction technique of Knutsson. This may elicit the 'gas' shadow, or demonstrate abnormal mobility of the vertebral spinal segments best shown in lateral x-ray studies.

These findings are all evidences of disk pathology. The last three are pathognomonic and indicate pathologic change in the disk.

Knutsson's maneuver is a valuable distraction technique. It is a method applied for the separation of apposed surfaces and the production of a 'gas' shadow.

Gas formation is infrequently present in the intervertebral disk spaces and in all locations in adults should draw attention to the likelihood of pathologic alteration. The common theories as to the formation of this 'gas' shadow are (1) that degenerating cartilage which contains sulfur yields



Fig. 3.—The Knutsson maneuver followed by gas formation. This maneuver consists of flexion and extension of the spine to their limits. As carried out in this office, this is done with the patient on his side in the jackknife position. It is especially difficult to demonstrate the gas formation if the patient executes these movements erect.



Fig. 4.—Vacuum phenomenon with markedly diminished disk space and subchrondral sclerosis. Excellent demonstration of moderately far advanced cartilage degeneration at the level of the fifth lumbar and first sacral vertebrae. Roentgenogram by courtesy of Dr. Louis Raider, Mobile, Ala.



Fig. 5.—Vacuum phenomenon in joint space of normal vertical height. Compare with figure 4.

a gaseous sulfate, and (2) that the gas appearing here originates from the body fluids. Air (gas) accumulates in the space left by a disintegrating nucleus pulposus when tension on the spine creates a partial vacuum and allows the gas or air normally present and held in solution in the body fluids to escape. This situation occurs only when the disk is under strain.

One of the obvious functions of the intervertebral disk is to separate the adjacent intervertebral bodies. The primary pathologic change is degeneration or rupture of the disk; protrusion and/or herniation of the disk is a complication of the primary change. The symptoms may be due to degeneration and/or protrusion of the disk.

Conclusion

Not infrequently forgotten is the injunction, primum non nocere. The art of medicine is the evaluation of the available and in most instances equivocal evidence. There has already been accumulated sufficient iatrogenic disease. If simple, fast, relatively painless and inexpensive studies



Fig. 6.—Old fracture with repair of the fourth lumbar vertebra following an accident. Vacuum phenomenon disk space below between the fifth lumbar and the first sacral vertebra. There is also some retro-displacement of the fifth lumbar vertebra on the first sacral vertebra. This patient has had chronic persistent radiating pain in the back dating from the accident. Roentgenograms by courtesy of Dr. Louis Raider, Mobile, Ala.

can be utilized and an attempt should be made to utilize them, the best interests of the patient are served.

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Seminole County School Mental Health Project

Progress Report

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Sincere concern for the mental health of Florida's citizens has existed in the minds and hearts of the public health professionals of the state for some time. One of Florida's most distinguished state health officers, Dr. J. Y. Porter, wrote as early as 1890 in Florida Health Notes that mental hygiene should be part of any school health program, and suggested that school teachers are key persons for promoting good mental health.

Dr. Porter's statement clearly indicates that programs for the prevention of mental illness and the promotion of positive mental health through a public health approach have been an important goal of the Florida State Board of Health for over 60 years. It is interesting that Dr. Porter's pioneer thinking regarding the prevention of mental illness related from the beginning to promoting mental health in the schools. The widespread interest in developing programs to prevent and control mental illness, and to promote sound public mental health is clear evidence of the accuracy of his prophetic writings.

The original emphasis in mental health programming during the first half of the twentieth century has been on improving the care of the mentally ill and this is still a major goal. Now there is a growing realization among experienced health professionals that much more is needed. The need for a broad approach to the problems of mental illness is now generally recognized, and although mental health workers find it difficult to agree upon program priorities, it is generally agreed that mental illness is mainly the business of the specialists, while public mental health is the business of everyone.

Dr. Dana Farnsworth, Psychiatrist and Professor of Hygiene, Harvard University, pointed out in 1957 that reliable and tested methods for promoting good mental health in the general population are conspicuously lacking. The traditional problem-solving approach of public health, however, which attempts to promote health programs through groups and communities seems to offer the best hope for immediate and progressive containment of the grim problem of mental illness and the successful promotion of good public mental health. One of the key groups which exerts a known influence in the life and health of the community is the schools. Presently in the United States there are 41 million people engaged in learning and teaching in our formal school systems, and 1.2 million of these are teachers. This represents a tremendous human force which, if appropriately motivated and supported and not interfered with too much, can accomplish great things in the area of mental health.

In Florida public health has been a working partner with education for many years for the promotion of good health in the schools. Recently, there has been a growing interest on the part of these two departments of state government in the development of coordinated school health programs which incorporate the principles and practices of good mental health. The need and urgency for mental health planning in the school health programs are emphasized by the size of the problems of mental illness within the school age populations. A study by the Department of Psychiatry

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Read before the Florida Health Officers' Society, Jacksonville, April 10, 1960.

of Columbia University revealed that over 10 per cent of children in schools now are emotionally disturbed and need professional mental guidance. The 500 child guidance clinics in the United States treat over 200,000 school age children each year for serious emotional illness. The 16 mental health and child guidance clinics affiliated with the Florida State Board of Health discharge each year between six and seven thousand children who required professional services because of emotional and mental problems. There are approximately 135,000 (3 per cent) retarded persons in Florida today. Out of the approximately 103,000 infants born each year in Florida, at prevailing rates, about 3,000 mentally defective infants are added to this number each year.

One of the most disturbing facts regarding the over-all mental health of school age persons was discovered recently when it was found that one out of seven young recruits for the Korean war was rejected because of a mental disorder. The seriousness of the problem of juvenile delinquency and dependence is indicated by the fact that, in 1957, 25,116 boys and girls were referred by juvenile courts to child welfare agencies for delinquency, dependence and abandonment. As a matter of fact, it is very easy to demonstrate that one of the greatest problems in our school system relates to mental illness.

Research Project

Realizing that mental illness problems significantly extend into the school experience of children, and recognizing the lack of tested knowledge needed for the promotion of good mental health, the Florida State Board of Health under the leadership of Dr. Wilson T. Sowder, State Health Officer, and the United States Public Health Service agreed to sponsor, with the approval and cooperation of the Department of Education, a research demonstration school mental health project. The purpose of the project is to study the existing school health programs with the goal of finding effective ways of incorporating good mental health principles and practices into the general school health program of the counties. One of the main ideas in the study is to observe the school health project of a selected county as carried out under the provisions and practices described in school health bulletin 4-D. From these observations it is hoped that ways and techniques for mental health promotion can be identified and described. The demonstration research design has been kept flexible to allow for other related studies of child behavior in a school setting and in the related family constellation.

The project is financed with State Board of Health funds and through a special grant to the state by the National Institute of Mental Health of the United States Public Health Service. A research clinical psychologist is assigned to the project by the Florida Medical Foundation. A psychiatric nurse works with the psychologist in carrying on the work of the project. The primary function of the two staff professionals is to act as scientific observers. They are responsible for collecting, analyzing and reporting data accumulated during the study. A final summary report will be published.

The mechanics of the study are based on the framework of the local school health program. Teachers nominate candidates from their classes as mental illness "suspects" of all types. These suspects are processed through the usual teacher, nurse, teacher-parent, and nurse-parent conferences. The psychiatric nurse works with the public health nurses in an in-service training relationship to help the public health nurse improve her mental health skills and also act as a psychiatric nurse consultant. The clinical psychologist works with the school personnel as a mental health consultant and carries on an in-service training program for principals and teachers in order to upgrade their mental health skills and sharpen their perception and judgment regarding abnormal and distorted behavior in school age children. The research psychologist directs the project and is responsible for the research design and for the final reporting of findings and conclusions.

Coordination for the research activities is secured through an advisory committee made up of representatives from the local health department, the county school system, the medical profession, and other interested and qualified persons from the community. Consultation is provided by the State Board of Health, the State Department of Education, and the Regional IV Office of the United States Public Health Service. Special consultation is obtained whenever it is needed, and paid for out of project funds.

For the first two years, the study was carried on in Volusia County, and was then moved to Seminole County in 1958 in order to compare results in counties with different social characteristics. While Volusia County is predominantly

urban, Seminole County is more rural in culture with limited mental health resources. Out of this undertaking it is hoped that new ways of dealing with mental health problems will emerge which can be applied even in deprived areas and in counties which contain few resources for handling mental health and behavior problems of school children.

Trends Demonstrated

After four years the study has demonstrated several interesting trends in school mental health. There follows a brief summary of these findings which should be interesting to the public health professional and physician:

1. It is clear that the present problem of mental illness in the contemporary school systems is irrevocably tied in with the family life experience of the child. It has been known for a long time that the family is the site of the beginning and the development of the human personality and that the family is the place where all the tension generated by social change comes to focus on the individual. From what we now know about emotional illness and its origins we can safely say that the problem primarily exists as a family epidemic. The tendency of the mental illness epidemic to divide itself into a nodal system of family units is carried over into the school life of the child. This is to say that the origins of emotional and behavior difficulties among school children are to be found mainly in the family experiences of the child.

The basis for this emphasis on the importance of family life experience on the mental health of the school child is found in the repeated observation by the observers in this study that the behavior patterns exhibited by emotionally disturbed children are the resultant of two frustrating forces acting upon the personality of the child. These children are literally caught between two stressful forces: the family and the school. Usually the factors which set off the emotional disturbance in a child are found within the social structure of the family. The disturbed child manifests his emotional discomfort through patterns of abnormal and distorted behavior. It frequently follows that this distorted behavior is carried over into his school life where many times new stresses and tensions are encountered. When these two tension-producing factors come to bear on the child, he will usually resort to types of behavior which will provide defense, comfort or escape. Essentially, the behavior pattern adopted is the resultant of the child's attempt to meet and solve his difficulties which originate in two separate social settings. It logically follows that if the emotionally disturbed child is to be helped, the help must be provided firstly by the family itself. The responsibility of the school in helping the emotionally ill child is nearly always secondary to that of the family. The school, however, needs to participate in the planning for the management and care of the sick child and can accomplish great things by cooperating with the families of these children and the family–helping agencies.

2. The second contribution of the Seminole County mental health study is not remarkable, but is, nevertheless, important in programming for mental hygiene services for school children. It has been demonstrated that sensitized classroom teachers are accurate detectors of suspected emotionally disturbed children. The key to effective teacher case-finding is a sensitized awareness on the part of the teacher created by a continuous in-service training program. When a teacher who is untrained in mental health principles and personality dynamics first begins to identify children she suspects of having a mental deficiency or emotional disturbance, there is a definite tendency to overselect and to nominate many children with minor behavior problems along with the seriously emotionally ill pupils. After a few weeks of informal instruction and on-the-job consultation with health professionals, a teacher begins to recognize the difference between the serious and the transitory minor behavior distortions. She becomes alert to behavior deviations and shows considerable skill in selecting the mentally ill and emotionally disturbed child for referral to professional services.

3. More important is a corollary finding that after a few months of working together with the psychiatric and psychological consultants both teachers and public health nurses become quite skillful at identifying emotionally ill school children and are competent to make appropriate referrals for diagnosis and management to the proper professionals or agencies. Actually, the trained teacher-nurse team can take care of up to 90 per cent of the cases of behavior problems in the schools. This is true, even in a community with limited mental health resources. The remaining 10 to 20 per cent need to be referred to a psychiatrist or mental health facility.

The practical significance of the last two findings of the demonstration is that with proper planning any county health department and local school system can successfully take care of 80 to 90 per cent of the school age children with behavior problems and minor emotional disturbances at the local community level. The remaining mentally ill children are usually appropriately referred to private physicians, guidance clinics, and other helping agencies.

4. Another significant phenomenon demonstrated by the project is that there seems to exist in most public school societies an inner "hard core" of children with multiple social and psychological problems. This "hard core," which makes up approximately 5 per cent of the total school population, is characterized by several consistent factors. These children or their siblings tend to have multiple problems and usually come from families which have multiple social problems. Their behavior problems tend to recur throughout their school career. This small residue of disturbed children seems to prevail throughout the school societies studied in Volusia and Seminole Counties. Finally, these unfortunate children apparently have a relatively poor prognosis and a dismal future unless they can be given and will accept much help from the community.

Conclusion

While no world-shaking discovery has occurred, it can be safely said that this research undertaking is paying off. It is demonstrating that new methods and better approaches to the promotion of positive mental health in schools are possible. Present plans are to continue the study project for several years, and hopes are high that this research effort will continue to make practical contributions to our knowledge of child behavior in the society of the family, school and community.

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A Prospective Study of Stroke

Preliminary Report

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In recent years increased interest has been shown in the field of cerebrovascular disease, and rightly so for this group of diseases is of paramount importance. It is recognized as the third leading killer in the United States today, having caused an estimated 192,980 deaths in 1958—5,120 of these in Florida. Another recognized fact is that there are from 1,800,000 to 2,000,000 persons living today who have suffered strokes. Many of these people are crippled and disabled to the extent that they are unable to care for themselves or to support their families if such be the case. It does not take much imagination to see that a great socioeconomic problem has been created by this condition.

Speaking then from a numerical as well as an economic standpoint, cerebrovascular disease presents quite a problem. Much is now being done in the fields of chemistry, neurology, pathology, surgery and medicine to uncover better methods of treatment and prevention and to provide better and more comprehensive rehabilitation.

Much is being done, but more is needed. This argument was emphasized by the Princeton Conference on Cerebrovascular Diseases (1954-1957) when it was pointed out (1) how desperately information of all types is needed concerning the group of diseases so often lumped under the heading "stroke" and (2) how urgent is the need for application of proven methods in the diagnoses and management of stroke cases. For these two reasons mainly, the Heart Program of the Florida State Board of Health thought it worth while to design a prospective study of stroke at a local city-county hospital. Not only did we hope the study would add to our general knowledge of strokes and possibly demonstrate some of the needs of stroke patients, but also it was thought

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that possibly new avenues for investigation might become evident through a general study of this type. This study is unique in that it deals not only with hospitalized stroke patients, but also those that are referred to their home or to the nursing home. This type of study has never been done before to our knowledge.

Planning

Our study was initiated Jan. 1, 1959, after careful consideration of personnel and budgetary requirements and the population that the hospital serves. The objectives of the study were reviewed in a meeting with responsible persons in the hospital and arrangements were made so that all necessary records would be available for examination. We selected for study the first 100 consecutive cases diagnosed as stroke in the emergency room of this city-county hospital. They included all those conditions where the cerebral blood supply was insufficient, such as hypertensive encephalopathy and cerebral artery insufficiency.

HOSPITAL.—The hospital is a general one of 315 beds that serves not only Duval County but four or five surrounding counties. The estimated population of this area is 500,000. Over one half of the patients served are of the Negro race and eligibility is determined by a social service department. Most all the patients are medically indigent, with only a small percentage being private patients. At the time of the study (January through May 1959) there were 18 interns, three medical residents and 10 surgical residents employed. There are 37 medical beds, 34 general surgery beds and four neurosurgical beds, which theoretically could be available to stroke patients. A complete outpatient service is maintained, and the emergency room is staffed by two interns day and night. Medical and surgical residents are available for consultation upon request. A physical therapy unit is located in the hospital and is headed by a full time physical therapist.

Personnel

The director of this study is the consultant to the Heart Disease Control Program of the Bureau of Special Health Services. Other personnel include a medical officer on special assignment from the Heart Disease Control Program of the United States Public Health Service, and a public health nurse who is engaged in various activities of the Heart Disease Control Program. Clerical services were believed adequate.

RECORDS.—A form for recording the desired data was prepared. Space was provided for the usual vital data such as age, race and sex, but also recorded was such information as history of previous stroke, associated conditions, disposition, cause of cerebrovascular accident, cause of death and treatment received. This information was generally taken from the emergency room, hospital and clinic records, but at times only the patient's family could fill the gaps of missing information.

Procedure

All patients were usually seen by the doctor and/or nurse within 24 to 48 hours following the emergency room visit. To do so meant visiting patients in the hospital, in the nursing home and in the private home. During these follow-up visits an attempt was made to evaluate the patient's progress, or lack of it as the case might be. This estimate was made by evaluating the patient's residual motor function and ability to carry on activities of daily living at each visit. These findings were compared with the initial impression. Numbers were used to represent degrees of disability, so that a small reporting form could be used. Disabilities were graded from zero to four with zero representing no disability and four representing total disability. Disabilities were determined by the project doctor and nurse—together and individually. Follow-ups were done weekly for the first month and every two weeks for the next two months. They, of course, varied in some cases where changes seemed to be occurring rapidly, or in cases where no changes had occurred in a month or so.

Comparison Group

We selected for a comparison group 200 cases that were seen in the emergency room during the same period of time that the original 100 cases were collected. These cases were selected by random number sampling from a total of 19,371 persons. This figure represents the total number of patients seen in the emergency room from January through May of 1959. Because the youngest person in our 100 case sample was 37 years of age, we limited our comparison group to those patients 35 years of age and over. These 200 cases were matched according to age groups comparable to those of the study group, the number in each age group being doubled. This plan was followed to guarantee that an adequate number of

patients would be had for comparison. We are now in the process of gathering data on these cases. The data being collected are confined mainly to (1) the frequency of previous stroke in this group, and (2) the frequency of hypertension, organic heart disease, diabetes, nephritis, and other diseases. The usual vital data such as age, race and sex, of course, are included.

Findings to Date

In presenting the preliminary findings, I believe it would be simpler and clearer to cover the material according to the categories shown on the form, overlapping when necessary to point out interesting observations. These figures have not been examined by a statistician; so most of the comments will be simply speculation on the subject and should not be considered the final comment by any means.

Age, Race and Sex.—There were 30 whites and 70 Negroes with an over-all average age of 64.4 and median age of 63. Of the 30 whites, 19 were males and 11 females. The median age was 71.5. Of the 70 Negroes, 33 were males and 37 females. The median age here was 61.5.

It seems to me that about the only significant observation here was that these patients generally fell into the older age groups, particularly those in the white race. Nevertheless, although this seems to be true, 54 per cent of the total number fell in the working age group of 35 to 64 years.

Very few data have been collected on the comparison group to date, but we do have the breakdown as to race and sex. There were 41 white males, 44 white females, 60 Negro males and 55 Negro females. The Negroes outnumbered the whites 115 to 85, but this preponderance of Negroes was expected. An analysis of the ages of the comparison group has not been done as yet, but since these cases were picked according to the different age categories of the study group, we can assume, I believe, that the average and median ages will be essentially the same for both.

Diagnoses.—Here the tabulations show 32 cases of thrombosis, 17 cases of hemorrhage, two cases of embolus, one case of cerebral insufficiency, one of anaphylactic shock and 47 cases entitled simply "CVA" or "stroke." These diagnoses were those listed in the emergency room, clinic or hospital records by the intern, medical resident or private physician in charge of the case. The finding that seems important here is the great number of diagnoses which gave no indication as to what the underlying problem might have been, that is, whether there had been a hemorrhage, thrombosis, embolus, or other vascular accident. Examination of the emergency room and hospital records perhaps gives something of an answer.

Previous Stroke.—There were 30 cases in which the patient had experienced a stroke before the immediate episode. Of the 30 patients suffering a previous stroke, 15 were dead within three months, giving a 50 per cent mortality. Of the 70 patients giving no history of previous stroke, 50 (70 per cent) were dead within three months. Here the recurrence rate is 30 per cent and this to me seems rather high. I believe, however, that many more cases need to be investigated before one could accept a figure like this. The standard textbooks of medicine make little reference to the over-all recurrence rate for stroke.

Date and Time of Stroke; Date and Time Seen by Doctor; Date and Time of Death.—Figures here indicate that in 90 per cent of the cases the patient was seen by a doctor within 12 hours following the cerebrovascular accident, but it was often difficult to ascertain just when the stroke had occurred. Of all those dying within three months, 38 per cent were dead within 24 hours, 64 per cent were dead within the first week, 80 per cent were dead at the end of two weeks and 94 per cent at the end of one month. These findings are similar to those of Dr. Milton Lowenthal, Associate Professor, New York Medical College, Department of Physical Medicine and Rehabilitation, who studied 232 cases of stroke in which the patients were hospitalized at the Metropolitan Medical Center, New York City. In his study 82 per cent of those dying did so within the first two weeks.

Disposition.—Forty-seven patients were hospitalized, 19 were sent to nursing homes, 28 were dismissed to their home, and six died in the emergency room. The most interesting finding in relation to the disposition of patients was the mortality breakdown. Of those hospitalized only six were still alive at the end of three months, a mortality of 87 per cent for this group. Of those sent to nursing homes, approximately 50 per cent died within three months, and of those sent home approximately 50 per cent died during this period. This outcome should not be a reflection on the hospital care, for when one considers that the prerequisite, in practically every case, for admission

of a stroke patient to the hospital is that the patient be unable to swallow. We can see why there might be such a high mortality. To me the surprising finding here is the large percentage that succumbed after being sent home or to a nursing home, and I wonder how many of these could have been salvaged by providing adequate hospital care.

ASSOCIATED CONDITIONS.—Here we listed only the more prominent conditions which were found to be associated with cerebrovascular accidents. In 55 cases a single associated condition was listed, whereas there were multiple (two or more) associated conditions in 25 cases. Hypertension alone was listed in 38 cases, organic heart disease alone in 12 cases, diabetes alone in five cases, diabetes and nephritis in one case, and pregnancy in no cases. There was a combination of hypertension and organic heart disease in 21 cases, of hypertension and diabetes in two cases, and of hypertension, organic heart disease and diabetes in two cases; there were 20 cases which supposedly had no associated conditions. In going over this material briefly, we find that organic heart disease and hypertension as well as a combination of the two were present in 62 of the 100 cases. Forty-four of the 65 total deaths came from these cases. We get here an idea of how frequently one may see hypertension and heart disease associated with cerebrovascular disease. We wonder also what influence they may have had on the over-all mortality rate.

CAUSE OF DEATH.—There were 65 deaths within the three month follow-up period, and in all but 12 cases the death certificate listed the cause as cerebrovascular accident or a specific type of cerebrovascular accident, such as hemorrhage, embolus or thrombus. In the remaining 12 cases an assortment of conditions given as the cause of death included myocardial infarction in three, cirrhosis in two, hypertensive cardiovascular disease in one, encephalomalaia due to atherosclerosis in one, uremia in one, pulmonary infarction in one and pulmonary edema and fibrosis in one. To me these diagnoses are fairly representative of the diseases which should be considered when a patient presents himself in a state of confusion, collapse or shock. The differential diagnosis of myocardial infarction versus stroke is often difficult.

IMMEDIATE TREATMENT, LONG TERM TREATMENT, AND SUPERVISION IN TREATMENT.—In discussing this particular part of the form I believe it would be best if we divided the patients into those living and those dead as well as giving general consideration to the entire group. First of all, for the entire group the general supportive therapy was quite adequate, but the nursing care and rehabilitation therapy seemed deficient. Anticoagulant therapy was used in two cases, and angiography was employed in one case. In no instance did we see the use of sandbags, blanket rolls, pillows, or footboards for support of the affected side. Some type of physical therapy (passive exercises) was ordered for six patients. In only one of these cases was therapy administered by a registered physical therapist. Of the seven hospital patients who lived through the three month follow-up period only one received physical therapy. No patient received occupational or speech therapy, for no properly trained instructors were available.

Of the patients sent to nursing homes, there was one who received physical therapy. This was administered by a registered nurse.

Of the 28 patients dismissed to their home and to the outpatient department, rehabilitation exercises were ordered for four. These exercises were administered by the family in three cases and by the visiting nurse in one case. No instructions were given to the patient's family for the use of pillows, blanket rolls and footboards.

EVALUATION OF PATIENT'S PROGRESS.—During the evaluations we attempted to classify every living patient as to the extent of the generalized disability. We did so by using the sum of the figures recorded during initial examination under the headings, "arms, legs, speech and swallow." A total of 0-3 indicated no disability, 4-6 indicated a slight disability, 7-9 indicated a moderate disability, 10-13 indicated a marked disability, and 14-16 indicated a complete disability. I think it should be pointed out now, however, that this has been the most discouraging part of the study. The figures we have do not have much significance for two reasons. First, when we were determining the patient's initial disability, we did not consider the effect a previous stroke might have and second, we did not define specifically, and with objective criteria, just what we meant by the words slight, moderate and marked disability, and just what the dividing line between these groups would be.

Of the surviving patients, eight were classified as having no disability, 10 as slightly dis-

abled, four moderately disabled, three markedly disabled and three completely disabled. Of the eight with no disability on initial examination, all can now walk and maintain activities of daily living. Two have returned to work. Of the 10 judged slightly disabled, seven are now able to walk; six are able to maintain activities of daily living. Four, however, require rather constant nursing care for activities of daily living. One has returned to work. Of the four judged to be moderately disabled, one is now able to walk and take care of himself; three require constant nursing care. The three classified as markedly disabled showed little improvement at the end of three months. All three required constant nursing care. Of the three judged to be completely disabled initially, two are now able to walk and take care of themselves, and only one requires nursing care.

These results seem to indicate that a fair number of the surviving stroke patients will regain many of their functions through their own initiative no matter what their original disability may have been. To give emphasis to this point, Dr. Lowenthal showed in his one year study that approximately 65 per cent of those surviving in his series benefited only minimally from rehabilitation care. Most of these patients, through their own efforts, had rehabilitated themselves.

Conclusion

In conclusion, I believe there are several important objectives this study has accomplished, in addition to giving an over-all appreciation and respect for cerebrovascular diseases. In the first place, we have learned that we as physicians, whether in public health or private practice, need to readjust our attitude toward the stroke patient; we need to improve our diagnostic approach and make use of the accepted, newer ideas in the active treatment and rehabilitation of patients with these diseases.

Secondly, the findings relative to mortality in the nonhospitalized patients indicate that something needs to be done to improve the situation. Future studies in stroke should be designed to investigate this problem more specifically.

Thirdly, the shortcomings of this study, with particular reference to evaluation of the patient's disability, have shown us that there is no substitute for adequate preplanning and a clear definition of the terms we employ.

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Death From Poisoning

Dade County (Metropolitan Miami), Florida

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How common is death from poisoning? What manner of death are poison fatalities? What poisons are responsible? Answers to these questions are provided by an analysis of all deaths from poisoning that occurred in Dade County during the period from March 1956 through December 1959 and studied at the office of the Medical Examiner.

Incidence

The total number of deaths in Dade County, the number of these deaths which were the subject of medicolegal investigation, and the total number of deaths by poisoning are listed. The listing is given by year, beginning with March 1956, when the Office of the Medical Examiner was inaugurated for Dade County:

Year	Total Deaths in Dade County	Medical Examiner Cases	Poison Deaths
1956 (Mar.-Dec.)	5,946	1,985	36
1957	7,702	2,661	58
1958	8,495	2,932	70
1959	8,546	2,820	77
Total	30,689	10,398	241

The 0.8 per cent incidence of poison deaths to total deaths in Dade County is twice the national figure of 0.36 per cent. In 1957 there were 5,910 deaths by poisoning reported in the United States, and 1,633,128 total deaths.[1]

The 2.3 per cent incidence of poison deaths to medical examiner cases is lower than the often quoted figure that approximately 5 per cent of all deaths requiring medicolegal investigation are due to poisons.

Manner of Death in Two Hundred Forty-One Poison Deaths

Suicide	150	62%
Accident	84	35%
Homicide	1	
Undetermined	6	3%

The corresponding percentages among the 5,910 deaths from poison reported in the United States in 1957 are 57 per cent suicide, 43 per cent accident, and less than 1 per cent homicide.[1]

In the six cases in the undetermined category death was due to barbiturates. A differentiation between accidental and suicidal manner of death could not be made in these cases on the basis of the evidence at hand. Undoubtedly some cases of death by barbiturate intoxication classified undetermined or accidental are instances of suicide. The tendency at the national level is to consider all cases classified undetermined, that is, accident versus suicide, as instances of suicide.

It is of interest that although poisoning conjures up in the lay mind an image of crime, homicide by poisoning is rare. This is the experience in the United States (30 homicidal poisonings among 5,910 poison deaths), as well as in Dade County (one homicidal poisoning, by arsenic, among 241 poison deaths). The "professional poisoner," in the fashion of the Borgias or Guilia Tofana, is extinct. The latter is credited with over 600 successful poisonings, and she allegedly died a natural death in 1651.[2]

The total number of suicides in Dade County, by all methods, during the 46 month period of this study was 495. The number of suicides from poison during this period, 150, is of approximately the same order as the number of suicides by gunfire, 181. In suicide by gunfire men outnumber women approximately 5 to 1, but in suicide by poisoning the sex incidence is approximately equal 80 females and 70 males. The poisons used in the 150 suicides are tabulated:

One Hundred Fifty Suicidal Poisonings

Barbiturates	99
Carbon monoxide	15
Nicotine	7
Phosphorus	5
Arsenic	4
Cyanide	4
Lye	2
Organic phosphates	2
Strychnine	2
Salicylates	2
One each:	8
Saniflush, hydrofluoric acid, Deprol, Placidyl, Doriden, chloral hydrate, Sleep-Eze, and quinine.	

From the Office of the Medical Examiner, Dade County.
Assistant Medical Examiner, Dade County.

Suicide never was and probably never will be entirely preventable. The accidental poisonings, however, fatal and nonfatal, should be almost entirely if not absolutely preventable. The national incidence of accidental poison deaths in 1957 was approximately 11 times higher than the number of polio deaths, respectively 2,533 and 221.[1] In fact, accidental poison deaths were higher than deaths due to polio, rheumatic fever, diphtheria, meningococcal infection, scarlet fever, typhoid fever and tetanus combined. One cannot escape the fact that poisoning is common. Pediatricians, who probably see more poisonings than any other medical group, have been among the first to emphasize the prevalence of poisonings and to propose preventive measures. Although children figure highly in poisonings, fatal poisonings are more prevalent among adults. Of 84 accidental poison deaths in this series, there were 17 children and 67 adults. The poisons responsible in each group are listed:

Poisons in Sixty-Seven Accidental Adult Deaths

Barbiturates	18
Methyl alcohol	17
Carbon monoxide	12
Ethyl alcohol	2
Paraldehyde	2
Parathion	2
Heroin	2
One each:	12
Lye, phosphorus, kerosene, carbon tetrachloride, pine oil, methyl bromide, gas fumes, thallium, carbon dioxide, aspirin, Placidyl, and isopropyl alcohol	

Poisons in Seventeen Accidental Children Deaths

Parathion	2
Kerosene	2
Arsenic	2
Phosphorus	2
Carbon monoxide	2
One each:	7
Lye, ferrous sulfate, aspirin, furniture polish, fly spray, thallium, and ipecac	

Summary

Analyzed are 241 deaths from poison which occurred in Dade County from March 1956 through December 1959. The incidence of death by poison among all cases of death in Dade County was 0.8 per cent, and the incidence in medicolegal cases 2.3 per cent. There were 224 adult and 17 children fatalities. Three agents accounted for almost three fourths of all adult poison deaths: barbiturates 52 per cent, carbon monoxide 12 per cent, and methyl alcohol 8 per cent. Suicidal poisoning was almost twice as common as accidental poisoning, and homicidal poisoning was rare. All 17 fatal poisonings among children were accidental, and with one exception occurred in the home. There was no one poison in the children's death which was predominant.

References

1. United State Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics: Mortality from Each Cause: United States, 1955-57, Vital Statistics—Special Reports, National Summaries 50:1-31 (Jan. 9) 1959.
2. Meek, W. J.:The Gentle Art of Poisoning, J. A. M. A. 158:335-339 (May 28) 1955.

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ABSTRACTS

Buccal Incision for Chin Implants. By Ralph Millard, Jr., M.D. South M. J. 52:1371-1374 (Nov.) 1959.

In this report the author seeks to encourage a simple approach to the correction of a receding chin. Homologous rib cartilage, easily kept in a bank and carved to shape, avoids a second operation on the patient, and insertion through a buccal incision produces no visible scar. Infection has been prevented by a mucosal flange flap, closure in two layers, postoperative pressure and antibiotics. He points out that a cartilage implant for a weak chin does more than increase chin prominence. It camouflages protruding teeth and takes up the slack of a hanging lower lip, both unattractive characteristics often associated with a receding chin. When the diminutive chin is overshadowed by a large nose, the deformity is doubly exaggerated and in fact calls for a double plastic attack—a nasal reduction and a chin implant.

Gastroschisis. A Method of Treatment. By Thomas D. Cook, M.D. Surgery 46:618-623 (Sept.) 1959.

Gastroschisis is a rare congenital malformation in which the abdomen remains open. This anomaly is believed to be due to incomplete fusion of the right and left ventral myotomal masses, as they replace the somatopleure to form the true body wall, at about the end of the twelfth week of intrauterine life. This paper reports the successful application of skin closure in a case of gastroschisis with marked disproportion between the size of the eviscerated mass and the capacity of the abdominal cavity, describes the surgical problem which remained, and presents a possible solution of this second obstacle to complete repair of the abdominal wall. Because of the absence of a membranous sac, development of the abdominal cavity and wall does not follow unaided as is the case with large omphaloceles following the first stage Gross operation. A procedure is presented for staged obliteration of the subcutaneous space by first suturing the muscles to the subcutaneous tissue. This method has resulted in returning the viscera to the abdomen, which has increased in size.

The Effect of Migration to Miami, Florida on Allergic Respiratory Disease. By George Gittelson, M.D. Ann. Allergy 17:596-601 (July-August) 1959.

A study of a group selected at random from the general population of the Miami, Florida, area indicated that a substantial number of people with allergic respiratory disease will improve as a result of migration to Miami alone. A similar study of a group selected from among patients attending the Allergy Clinic at Jackson Memorial Hospital in Miami indicated that a substantial number of patients with allergic respiratory disease will not improve as a result of migration alone. It is suggested that because this second group is a selected group, the results do not reflect the results in the population as a whole as do the results of the study of a random group. Since the results of the study of this selected group correlate with the previously published expressions of medical opinion, it is suggested that previous reports were based on observations of selected rather than random groups. The striking finding of the survey was the pronounced difference in the result, depending on the group from which the sample was drawn. Analysis of these groups indicated that hay fever is a rare manifestation of allergy in Miami. The results indicated that it is possible for initial symptoms of asthma or allergic rhinitis to develop in Miami. Sex, race, and previous place of residence did not seem to play a part in improvement. It was concluded, however, that age and length of residence in Miami may be of slight importance.

Clinical and Pharmacological Observations of the Effects of 9-α-Bromo-11-β-Ketoprogesterone in Patients With Carcinoma of the Breast. By U. Jonsson, M.D., J. Colský, M.D., H. E. Lessner, M.D., O. S. Roath, M.D., R. G. Alper, M.D., and R. Jones, Jr., M.D. Cancer 12:509-520 (May-June) 1959.

A report is made of observations on 34 patients with advanced carcinoma of the breast treated with 9-α-bromo-11-β-ketoprogesterone (BOP). Seven patients in this group showed ob-

jective evidence of improvement, and, in addition, nine patients showed subjective improvement only. Remissions were observed lasting up to five and a half months. Primarily, younger patients were observed to respond to the drug. Pharmacologic observations on the drug are reported, and it is believed that the drug acts primarily as a progestational agent although mineralocorticoid activity is present.

The Fate of the Corpus Albicans: A Quantitative Approach. By Robert V. Joel, M.D., and Alvan G. Foraker, M.D. Am. J. Obst. & Gynec. 78:1272-1274 (Dec.) 1959.

In this initial study of the fate of the corpora albicantia, a planimetric evaluation of various components of the ovaries of premenopausal and postmenopausal women was made. Hematoxylin and eosin-stained sections of ovaries from 14 premenopausal and six postmenopausal women were studied. Planimetric methods after image tracing on graph paper were employed to measure the corpora albicantia of these ovaries selected from the authors' surgical files. No significant differences were found concerning the quantitative aspect of the corpora albicantia of premenopausal and postmenopausal women. The problem of the fate of the corpora albicantia formed during the reproductive life of a woman is thus introduced, and the next phase of the study will be directed along morphologic lines.

Report on Carcinogenic Action of Certain Agents on Urinary Bladder of Dogs. By Milton M. Coplan, M.D. J. A. M. A. 172:1611-1618 (April 9) 1960.

In this Chairman's address, presented before the Section on Urology at the 108th Annual Meeting of the American Medical Association, Dr. Coplan reports on the results of experiments carried out by a research team under the direction of William B. Deichmann, Ph.D. in the Experimental Laboratories of the University of Miami School of Medicine to determine whether or not certain industrial chemicals are carcinogenic to the urinary bladder. The experimental proof, presented here, establishes the carcinogenicity of two aromatic amines, namely, para-aminobiphenyl and and para-nitrobiphenyl, to the urinary bladder of the dog. Urinary bladder tumors were produced in four dogs by administration of para-aminobiphenyl. The time intervals from administration of the compound until tumors were observed from 21 to 34 months. The pathologic changes in all cases were those of medium grade squamous cell carcinoma. Investigation of para-nitrobiphenyl was also carried out on four mongrel dogs. In three, tumors of the bladder developed in 25, 33, and 33 months, respectively, but the fourth dog was still free from tumor after 33 months. Pathologically, the tumors produced in these dogs were essentially identical with the tumors produced in the dogs exposed to para-aminobiphenyl. The results corroborated the previous work of Walpole and co-workers that para-aminobiphenyl is carcinogenic to the bladder of dogs, and of Melick and his group that the compound is carcinogenic to the human bladder.

Subacute Bacterial Endocarditis: Report of Case with Certain Unusual Features. By Martin S. Belle, M.D., Maurice Rich, M.D., and Benjamin G. Oren, M.D. South. M. J. 53:70-72 (Jan.) 1960.

Prior to the advent of the sulfonamide preparations and more recently the antibiotics, subacute bacterial endocarditis was regarded as a fatal disease. Nowadays a significantly high proportion of the patients with this disease can be cured by prompt recognition and sufficiently early administration of the proper antibiotic or combination of antibiotics. In this article the authors report a case of subacute bacterial endocarditis which they consider noteworthy because of several unusual features. The infection developed in spite of adequate prophylactic administration of benzathine penicillin G (Bicillin), as recommended by the Committee on Prevention of Rheumatic Fever of the American Heart Association. It was manifested by extreme and unusual resistance of the organism cultured from the blood to antibiotics. The use of ristocetin (Spontin) apparently produced a severe granulocytopenic reaction. A central nervous system reaction of diffuse skeletal muscle twitching occurred with the use of nitrofurantoin (Furadantin). Despite the pronounced resistance of the organism to the antibiotics, defervescence and apparent clinical cure resulted.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Day of Reckoning

November 8, 1960—Election Day—may well be a day of reckoning for the medical profession in these United States. Since the final defeat of the Murray-Wagner-Dingell bill in the late 1940s, there has been a progressive and piecemeal attempt to advance this type of socialistic legislation, nibbling at the foundations of traditional, conservative medical care and at the democratic free enterprise system. For us, as physicians, this persistent undermining of those tenets that we continue to fight for reached its fastest tempo in the recent unlamented Eighty-Sixth Congress, when, through the concerted efforts of organized medicine and loyal friends in high places, we were able to stave off the beginnings of compulsory health insurance under law. We accepted as the least of several evils a law permitting another alleged government handout to cover the cost of medical care for elderly citizens.

None of us is naive enough to consider this the ultimate triumph of good over evil. Labor and the Democratic party have brazenly announced their determination to make medical care under the Social Security system their goal. Both parties have devoted major planks in their party platforms to health care and medically related subjects. This is a vote-getting appeal. It is human to appreciate those showing concern for one's welfare.

But note the approach, the flippant wave of the hand with which the Democratic platform would oversimplify the health care of the aged: "The most practicable, easy to provide health protection for older people is to use the contributory machinery of the social security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for social security coverage, we shall provide corresponding benefits by appropriations from the general revenue." The government taketh away from the many and the government giveth back to the few.

The Republican platform takes note of some of those features in previous legislative proposals that were anathema to most of us. "Development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome costs of health care. Such a program should provide the beneficiaries with the option of purchasing private health insurance—a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population; protect the personal relationship of patient and physician; include state participation."

Your attention is directed to a synopsis of the "Health Planks in Party Platforms," on the opposite page. Read them and then, weighing the value and sincerity of such platforms, decide whom you will support on November 8, 1960, the Democratic candidates with their socialistic attitudes of tax and spend, of paternalism and the government dole, or the Republican candidates, conservative by comparison, seeking to assist with dignity, not to disburse and control.

Why is November 8, 1960 a day of reckoning? For us as physicians, it could be the last Election Day when we can exercise our voting franchise with pride in our profession, as physicians free to practice as we know best, not as slaves of a governmental bureaucracy. Your vote and the votes of those you may influence should be for more freedom, not more control; for community endeavor, not centralization of government; for life, liberty and the private practice of medicine.

Leo M. Wachtel

Pertinent Planks From The Party Platforms

HEALTH MANPOWER

DEMOCRATIC

- Propose federal aid for constructing, expanding, and modernizing schools of medicine, dentistry, nursing, and public health.
- Provide scholarships and other assistance to help offset costs of medical education.

REPUBLICAN

- Pledge federal help in building schools of medicine, dentistry, public health, and nursing.
- Provide financial aid to students in these fields.

MEDICAL RESEARCH

DEMOCRATIC

- Step up medical research on cancer, heart disease, arthritis, mental illness.
- Summon the nation's most distinguished scientists in the fields of heart disease and cancer to map a coordinated long-run program for the prevention and control of these diseases.
- Provide increased federal support for psychiatric research and training, and for community mental health programs.

REPUBLICAN

- Pledge continued federal support for a sound research program aimed at both the prevention and cure of diseases, including mental illness . . . and for radiological medicine.
- Apply promptly the results of research.

  "We believe the Federal roles in research to be in the area of (1) basic research which industry cannot be reasonably expected to pursue, and (2) applied research in fields of prime concern such as . . . public health . . ."
- Endorse federal contracting for research.

  "(With) allowance for reasonable charges for overhead and management."
- Back international health research programs.

HEALTH CARE FOR THE AGED

DEMOCRATIC

- Provide medical care benefits for the aged under the existing social security insurance system.

  "We reject any proposal which would require such citizens to submit to the indignity of a means test."
- Provide corresponding benefits, by appropriations from the general revenue, for older people not covered by social security.
- Raise the standards in nursing homes and other institutions for the aged.

REPUBLICAN

- Provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome medical costs . . . with the option of purchasing private health insurance.
- Support Federal-State grant programs to improve health, welfare and rehabilitation services for handicapped older persons.
- Improve standards of nursing home care.
- Protect the personal relationship of patient and physician.

FOOD & DRUG ADMINISTRATION

DEMOCRATIC

- Review the practices of federal agencies, with an eye to speedier decisions.
- Provide the money and the authority to strengthen the Food & Drug Administration.

REPUBLICAN

- Pledge continued strong support of the Food & Drug Administration.
- Pledge new legal weapons for the Food & Drug Administration.

HOSPITALS · · · VETERANS

DEMOCRATIC

- Expand and improve the Hill-Burton hospital construction program.
- Provide increased [medical] facilities, including nursing home facilities, for all needy veterans.

REPUBLICAN

- Raise the standards of medical care for veterans, with increasing emphasis on rehabilitation.

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Symbiosis

The primary function of an intern is to gain knowledge in a practical and practicable way. The days of apprenticeship when an intern received only Spartan fare and drudgery in return for knowledge are now obsolete. The recent shortage of interns has made it apparent to even the most isolated staff that house physicians are no longer slaves. Because even teaching hospitals have begun to feel the vacuity of unfilled house staff positions, the medical schools associated with them have attempted and are succeeding in diverting interns from community hospitals to teaching institutions. Medical schools impress their students with the truth that the more training they have, the better physicians they will become, but also imply the half truth that only in a teaching hospital will adequate training be obtained. The quest for knowledge for its own sake, an unhurried and unharried existence, and a continual bath in the celestial aura of research are among the appetizing baits used to lure the better students to the hospitals associated with their alma mater. It is indeed only the poorer student or one with an extremely strong personal motivation who now escapes the snare and does not remain at a teaching hospital for at least a few years before entering practice.

The various accrediting boards, composed for the most part of retired medical school instructors, physicians who have held administrative positions and retired military personnel, have further hindered community hospitals from obtaining house physicians by unrealistic requirements which are not applied to teaching institutions. The life or death of a community hospital training program often depends on a 24 or 48 hour inspection tour with the major portion of the time spent savoring the sauce and ignoring the meat.

There is no doubt that the community hospitals require closer supervision and that they cannot give the same training program as teaching hospitals, but to condemn the community hospital because of this fact is to belie the truth that neither type of institution is capable of turning out a complete physician. The cloistered existence, the endless conferences, the interminable ward rounds, the obeisance to the gods of research in themselves do little to enable a practicing physician to treat his patient better five years after leaving a hospital. Inadequate his-

tories, haphazard physical examinations, and the prescription of useless and expensive drugs also do little towards making the physician trained in the community hospital a desirable addition to the profession. Yet, the same standard cannot be used in judging these hospitals and an attempt to make a community hospital a replica of a teaching institution is as foolish as pasting peacock feathers on a crow.

The only reason for a physician's existence is to treat the sick. In American medicine, community hospitals have become an integral part of patient care. These hospitals need adequate house staffs whose training must be mutually advantageous in a realistic sense to both the practicing physician and the trainee. Medical schools, teaching hospitals, and accrediting boards must not detract from nor burden with oppressive rules and regulations this achievement, for to restrict the community hospital is to place shackles on the practice of medicine.

Perhaps if medical schools were to imbue their students with a greater degree of skepticism, attempt to give them an ever questioning mind and teach them to look for and find the answers themselves instead of freely providing them, it would benefit both the student and the community hospital. Perhaps if the medical schools could inculcate each student with the philosophy that no problem in medicine has a trite answer, that every patient presents a chance for research as great as any laboratory, and that few delights in the world give quite the satisfaction of constantly using new approaches to solve new problems in medical care, the necessity for many regulatory boards would disappear.

It will be only by empathy between the medical schools and the practicing physicians that a better medical student will be graduated and turned over to a community hospital for a training which will be beneficial to the student, the community and the patient, and it is the students of today who will staff and maintain the community hospitals of tomorrow.

J. J. L.

Contact Lens
To Use or Not To Use

What are these little discs of glass and plastic that have become one of the latest fads of fashion? Are they safe? Are they injurious to the eye? Do they correct any defects? What should we, as physicians, tell our patients when they ask us about these lenses, or should we advise them at all?

Recently the House of Delegates of the American Medical Association recommended that contact lenses be fitted only by trained ophthalmologists. Consequently, doctors are definitely in the picture of contact lens care.

Contact lenses are small lenses, usually plastic, designed to fit either over the cornea or over the entire sclera to correct a refractive error. The two main types are referred to as corneal and scleral lenses. The corneal lens is a small disc seven to nine millimeters in diameter which floats on the surface of the cornea on the tear film. The scleral type is a much larger shell which fits between the eyelids and the sclera. It is the more difficult of the two to use and to fit.

Contact lenses were first suggested in 1827. Sixty years later, in 1887, the first successful pair was made by a skillful glass blower in Wiesbaden, Germany. These lenses were used in the treatment and prophylaxis of a crippling disease of the eyelids. Later that same year, in Zurich, the first of these lenses were used for refractive correction, and the name "contact lenses" was coined. From this time until 1938, contact lenses were infrequently used due to the lack of safety of the glass lens. In 1939, the first successful plastic lenses were made and since that time approximately ten million pairs have been sold in the United States.

There are three groups of patients who may wear a contact lens happily and successfully. The first group are those persons who have some abnormality of the eye or the eyelids. This includes scarred eyelids tending to scratch the

delicate cornea, and irregular corneas secondary to injuries or congenital deformities. In these patients with mixed astigmatism the contact lens will provide better vision than they could ever expect with regular glasses. Similarly, in keratoconus, a thinning and bulging forward of the cornea, the contact lens will often decrease the bulging for a long period of time and improve vision.

The second group are patients with anisometropia, a marked difference in the vision between the two eyes making coordination difficult. Occasionally, with a single contact lens the patient can achieve good binocular vision and depth perception.

The third and largest group is composed of those patients who need glasses but do not want to wear them for one reason or another. It includes policemen, soldiers, sailors, athletes and charming young ladies. These people find much greater freedom of action through their use of contact lenses than with traditional glasses as well as a definite cosmetic advantage.

What is entailed in examining a patient for contact lenses? First, he should be thoroughly examined by an ophthalmologist to see if the overall physical condition of the eye as well as its refractive error is such that he can anatomically wear the lenses and that there are no contraindications. The patient must also be evaluated as to his motivation and perseverance. Then the eye must be carefully measured for the lenses. The lenses are then ordered, carefully polished and filled. They must be examined carefully to make sure that they are floating well on the tear film and that there is no contact between lens and eyeball. Wearing time must then be slowly and tediously increased. During the initial weeks the lenses must be checked frequently so that as they settle on the eyes they do not change, warp, or produce a corneal touch and consequent abrasion. If this should develop, a new lens with a corrected curvature must be substituted. The average patient can wear the lenses from eight to 14 hours a day, but it takes a person with a good deal of perseverance to put up with the trials and tribulations of wearing these invisible glasses and of getting used to them. Even then the lenses should be checked periodically by an ophthalmologist to insure a continued fit.

Contact lenses, like all advances in medicine, have their advantages and disadvantages. They may be a godsend in either beauty or sight function on a properly selected and treated wearer; but when improperly advised or applied, they may prove disastrous.

T. S. E.

President Wachtel Popular State Speaker

Dr. Leo M. Wachtel of Jacksonville, President of the Florida Medical Association, has been busy in recent weeks addressing lay groups throughout the state. His subject at a meeting of the Jacksonville Area Chamber of Commerce in mid-September was "Medical Care for Senior Citizens —Political Football." He made it quite clear to this joint meeting of the Chamber's city, county, state and national affairs committees that the nation's physicians resent all attempts to tie medical care in with a tax system that would present a foot-in-the-door to compulsory health insurance and lower the quality of medical care for all people of this country. "Physicians are for medical care for all, including the aged," Dr. Wachtel said. "We feel that physicians are best able to determine how that care should be given. We resent most of all that the problem of medical care for the aged should be kicked around for political purposes." He explained the recent federal legislation and commented upon the continuing agitation for socialization which keeps medical care for the aged a major campaign issue in this election year.

The policy of the American Medical Association, adopted by its House of Delegates last June, he said, is that personal medical care is primarily the responsibility of the individual. "When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept. . . ."

Florida has for several years had an effective and active plan of hospital care for the medically indigent, Dr. Wachtel reported. It resulted from a study made by a Citizens Committee appointed by the Governor, and in 1955 the legislature set up a program for indigent hospital care on a state and county matching plan to provide funds, the program to be administered at the county level, and under the supervision of medical personnel. "The Florida Medical Association," he continued, "was insistent that physicians be permitted to provide their services to these indigents in the traditional manner of the profession without cost to the patient or the plan. . . .We stand unalterably in favor of care for those medically in need as locally determined, through a program locally administered, supervised by doctors, not bureaucrats."



Dr. Wachtel

The Downtown Lions Club of Jacksonville had Dr. Wachtel for its speaker at its last meeting in September. He spoke on the same subject at that time.

Dr. Wachtel presented an address on the "Need and Importance of Cooperation and Understanding" before a School Health Conference in Gainesville late in September. He pointed out that cooperation is a two way street and suggested that official medical groups become more active in making their services known and that school administrators and county health departments call upon them more frequently for help.

Reviewing the Florida Medical Association's interest and participation in school health on the state level, he spoke of the Association's Committee on Child Health which has functioned through the years and of its present expanded role. Early in 1958, he related, in order to assure the availability of authoritative medical advice in health matters and to establish a definite channel through which its services could be provided, the Florida Medical Association requested the State Department of Education and the State Board of Health to consider setting up a School Health Medical Advisory Committee to the two state agencies. This suggestion was received enthusiastically, and the Association's Committee on Child Health was appointed to serve in this capacity. This Advisory Committee has held several meetings during which a great variety of school health matters was discussed and acted upon, and it is available at all times for consultation and advice. Dr. Wachtel emphasized, however, that it will assist with local matters only when problems arise which cannot be settled at the city or county level. One of the major objectives of the program is to have advisory committees or joint endeavors in every local area.

Speaking before the Florida Division of the American Cancer Society at its annual meeting in Fort Lauderdale early in October, Dr. Wachtel discussed the cancer of socialism which, in the form of health legislation temporarily defeated, has now "metastasized to the Democratic party platform and to first place on organized labor's list of the 'big five' proposals for next year's legislative activities." He added, "Call it carcinoma or call it sarcoma, it is still cancer. Your continued support to eliminate this disease will be invaluable."

Dr. Wachtel then explained the import for Florida cancer control of the Mills Bill, H.R. 12580, passed by the Eighty-Sixth Congress. This bill authorized "federal participation in approved state plans to furnish medical services to aged individuals who are recipients of old age assistance and for needy individuals sixty-five years of age and over (estimated to be one million) and whose income and resources, as determined locally, are not sufficient to meet the cost of necessary medical services." In effect, this legislation will increase the funds available for the medical care of public assistance recipients as well as total funds for the program of "Hospital Service for the Indigent," he stated, provided such expenditures are not earmarked for a specific disease. "The fact," Dr. Wachtel continued, "that the new federal legislation does not make any discrimination between acute and chronic illness for the use of federal-state matching funds will eliminate

any remaining question of the eligibility of cancer patients for the use of such funds."

In conclusion, Dr. Wachtel noted that the services of those who served without pay, if evaluated, would exceed in cost the total expenditure of funds for cancer control in Florida in 1959-1960. "Let me reiterate," he said, "it is our earnest desire to continue to be permitted to serve the less fortunate. This we can do only while we remain unfettered by socialistic practices and arbitrary governmental controls. We invite your help in keeping American Medicine—yea, even all American enterprise, free."

Marianna Physician Nominated for National Award

Dr. James T. Cook Jr. of Marianna has been selected as Florida's 1960 nominee for The Medal of the American Medical Association For Exceptional Service by a General Practitioner. The Board of Governors of the Florida Medical Association at its September meeting chose Dr. Cook as Florida's candidate for the award from among several physicians whose names were submitted from throughout the state. Dr. Leo M. Wachtel of Jacksonville, President of the Association, announced that Dr. Cook along with general practitioners nominated from other states will be considered for the national honor. Established in 1947, the award is conferred annually upon a family physician in recognition of his contributions to his community in health and civic affairs. It will be presented this year during the Clinical Meeting of the American Medical Association, to be held in Washington, D. C., from November 28 through December 1.

Dr. Cook's name was submitted to the Association's Board of Governors by the Florida Academy of General Practice because he represents "not only the modern counterpart of the respected traditional family doctor, but also a good father and husband, an active citizen who contributes materially to the civic and cultural welfare of his community, and a leader in the organized activities of his profession." He personifies the new concept of the general practitioner of today which is rapidly gaining recognition in the state and the nation.

A native of Georgia, Dr. Cook was born in Porterdale 44 years ago. After graduation from high school in nearby Covington, he received his academic education at Emory at Oxford and later at Emory University in Atlanta, where the A.B. degree was conferred upon him in 1937. For his medical training he attended Emory University School of Medicine and was awarded his M.D. degree in 1941. His fraternities are Phi Delta Theta and Phi Chi.

After completing an internship at Emory University Hospital, Dr. Cook joined the Army Medical Corps and served overseas during World War II. Assigned to the Eighty-Third Infantry Division, he rose from Assistant Battalion Surgeon to Commanding Officer of a Collecting Company. During his combat experience in this capacity, he received five battle stars, from Normandy through Germany, and the company he commanded received a citation for meritorious service during these campaigns. Twice he was awarded the Bronze Star in addition to the Combat Medical Badge.

Upon discharge from military service in 1945, Dr. Cook entered the general practice of medicine in Marianna. Since that time he has participated in innumerable social, business and medical activities of his community and has engaged in various medical activities on the county and state level. Locally, he became the first male president of the Parent-Teacher Association and has served on many committees in the Boy Scout and Girl Scout organizations. A devoted member of the Rotary Club since 1946, he has served in various official capacities and was its president in 1954-1955. He is also a past president of the Sportsmen's Club, which he helped to organize. A member of the board of stewards of the Methodist Church, he is also on the board of directors of the Marianna Country Club. For years he has served on the board of directors of the Civic Music Association and at the present time is its president. In 1958, his success in getting the local golf course refurbished led to his appointment to the Advisory Council of the Florida Caverns State Park, which contains the course. Last year, Governor Collins appointed him to the Florida State Board of Parks and Historic Memorials, and he is now secretary of that body.

Dr. Cook has been a leader in the Jackson-Calhoun County Medical Society; he has served on many committees and is a past president. For years he has been Chief of Medicine at Jackson Hospital in Marianna, except for two years when he was Chief of Staff. From its inception, he has



Dr. Cook

been the director of a charity Heart Clinic for his county, which he organized and which for some time was the only heart clinic between Jacksonville and Pensacola. His interest in cardiology, although secondary to his interest in his large general practice, resulted in his recent nomination to a second term as a member of the board of directors of the Florida Heart Association. He is now a member of the clinic committee and of the professional education committee of that body.

At the state level, Dr. Cook has for some years been a regular delegate to the annual meeting of the Florida Medical Association and has served on reference committees. He is a past vice president of the Association and last year was chairman of the Committee on Liaison with the Florida State Board of Health. For several years he has served as a member of the Advisory Committee to the State Board of Health for Medical Student Scholarships and is now a member of the Association's Committee on Physician Placement.

Active in the fight against socialized medicine, this intrepid general practitioner was among the organizers of the Florida Medical Committee for Better Government. He was for several years either chairman or co-chairman for his district and at the present time is president of this organization.

Dr. Cook has long been an active member of the Florida Academy of General Practice and for the last three years has been chairman of its legislative committee. In 1959 he became a member of its board of directors and in 1960 became president-elect.

In 1942, Dr. Cook and Miss Lillian Schwencke of Thomasville, Ga., were married. They have one son and three daughters. Dr. Cook has one sister, Mrs. Marjorie Tolan, who is at the present time president of the National Society of X-ray Technicians. His only brother, Homer, lost his life in action in World War II. Dr. Cook is an avid golfer and shares with his entire family a keen interest in music.

Florida Pediatric Society Meets Nov. 16-19 in Jamaica

The Annual Fall Meeting of the Florida Pediatric Society will be held in Jamaica Wednesday through Saturday, November 16-19, according to the program as released by Dr. Harry M. Edwards of Ocala, president. An invitation to the meeting is extended to all members of the Florida Medical Association; those interested should contact Dr. John H. Cordes Jr. of St. Petersburg, who is secretary of the Society.

The scientific program will be presented by Dr. Ralph V. Platou, Professor of Pediatrics and Head of the Department of Pediatrics at Tulane University School of Medicine, New Orleans, and Dr. Helen Reardon of Philadelphia, Pa. Dr. Platou's presentations on Thursday include a Kodachrome Clinic and discussions of "Splenectomy and Infection" and "Diphtheria" and Dr. Reardon will present "Hyperosmolarity—Diagnosis and Treatment," and "Tongue Manifestation of Local and Systemic Diseases."

On Friday, Dr. Platou will discuss "Dermatology in the Newborn" and "Mongolism." Dr. Reardon's topics are "Evaluation of the Newborn," "Biochemical Studies and Management of the Offspring of Diabetic and 'Prediabetic' Mothers" and "Water Electrolyte Disturbances Associated with Central Nervous System Disease in Infancy and Childhood." The scientific program will be concluded on Saturday with a Clinical Conference and a discussion period entitled "Stump the Professors."

The business and social aspects of the program include a get acquainted hour for the ladies on Thursday morning, a cocktail party that evening; a meeting of the executive committee of the Society Friday, and on Saturday business

meetings of the Society and the Florida Chapter, American Academy of Pediatrics and the annual banquet.

In addition to Drs. Edwards and Cordes, the other officers of the Society are Dr. Joseph K. David of Jacksonville, president-elect and Dr. Fred I. Dorman Jr. of Lakeland, treasurer.

1960 Clinical Meeting American Medical Association Washington, Nov. 28-Dec. 1

The Fourteenth Clinical Meeting of the American Medical Association will convene in Washington, D. C., on November 28 and continue through December 1. All of the scientific sessions will be held at the District of Columbia National Guard Armory. The House of Delegates will hold its meetings at the Sheraton Park Hotel. The nation's capital will for four days be the capital of American Medicine, and its attractions added to the appeal of the exceptionally fine program should draw an unusually large attendance.

The theme for this year's convention is "New Developments in Old Diseases and Old Developments in New Diseases." The program offers an informative cross section of medicine for all physicians—general practitioner and specialist, practicing physician and research scientist. Many lectures, symposiums and group discussions as well as hundreds of scientific and industrial exhibits have been scheduled to appeal especially to the physician in family practice. Participants will include proponents of both sides when different views exist on the management of a disease or medical condition. On one symposium a layman will speak on coronary disease from the patient's viewpoint.

Some of the topics to be covered by leading physicians and scientists from across the nation include gynecology, hematology, obstetrics, coronary disease, pathologic nodules, psychiatry, artificial kidneys, orthopedic surgery, ophthalmology, diarrhea, antibiotics and tranquilizers. The timetable of discussions has been arranged so that physicians may attend the maximum number of sessions and participate in discussions in the particular fields in which they are most interested. Starting at 9:30 a.m. on Monday, November 28, and running until 11:30 a.m. on Thursday, December 1, three sections in both morning and afternoon will be held simultaneously in separate rooms at the Armory. One section will be devoted to presentations of formal papers, another to panel discussions, and the third to symposiums; all will have question-and-answer periods.

Approximately 125 entries in the Scientific Exhibit will be displayed in the Armory. Many of them will relate to such specific subjects as cardiovascular conditions, arthritis and rheumatism, and cancer. Others will be grouped into rather broad areas such as neurology and psychiatry, pediatrics, orthopedics, dermatology, drug therapy, surgery, ophthalmology and otolaryngology, obstetrics and gynecology, and laboratory and clinical investigation. Special demonstration exhibits on fractures and problems in delivery will also be included.

Medical motion pictures will be shown at the Armory, as well as closed color television showings originating in Georgetown University Hospital. Six one hour television presentations will be devoted to dermatology, pediatrics, emergency treatment of major injuries, newer methods of surgical treatment of peptic ulcer, orthopedics and pathology.

The detailed planning for this Clinical Meeting has been directed to the one goal of giving the physician the latest, up-to-the-minute scientific information. It serves as a kind of postgraduate course in medicine which provides him with all the major scientific advances under one roof. Florida should be well represented among the thousands who will avail themselves of the opportunity to attend this meeting in the heart of the nation's capital with all of its imposing dignity and rich historical tradition.

Florida Physicians Commended For Legislative Activities

Members of Florida's congressional delegation played important roles in laws enacted by the Eighty-Sixth Congress to help provide better medical care for the aged needy sick and at the same time successfully opposed legislation to provide a federal program of hospital and medical care for all social security recipients by means of a federal compulsory tax.

Representative Sydney Herlong is a member of the House Ways and Means Committee which

conducted an extensive two and one-half year investigation of all such proposals made to the Congress and conducted open hearings in which the Florida Medical Association participated. As a result of this study in which Representative Herlong played an important role, the Mills bill was presented and passed with all members of the Florida delegation voting favorably. The Forand bill was rejected by the committee.

The Senate Finance Committee, of which Senator George Smathers is a member, considered this legislation, reporting the Mills bill and adding the Kerr Amendment increasing funds available for medical care of public assistance recipients.

The Senate passed these bills and rejected all Forand type legislation, and Senators Smathers and Holland both played leading roles in this action to provide better medical care for the needy aged sick.

All physicians who assisted in defeating compulsory health insurance for the aged are to be congratulated. A letter from the American Medical Association expressing this view follows:

September 8, 1960

Leo M. Wachtel, M.D.
President
Florida Medical Association
2708 St. Johns Avenue
Jacksonville 5, Florida

Dear Doctor Wachtel:

I would like to take this opportunity to thank you, the members of the Florida Medical Association, and the staff members of your State Office, for their splendid cooperation during these past two years in our effort to defeat compulsory health insurance for the aged. Certainly, Medicine's hope for the future lies in the dedicated efforts of the many individual physicians and staff members who have worked so tirelessly to help preserve the practice of medicine as we now know it.

It would be my personal wish to be able to write to each individual member of your Association to express my appreciation for their cooperation in winning this important battle for American medicine, but I am sure you realize this task would be most difficult in the light of the many persons who participated.

May I, through you, the President of your Association, express the appreciation of the entire staff of the American Medical Association and my personal thanks. I hope you may find it convenient to relay this message to the members of your Council at its next meeting.

Again, thanks for your help.

Sincerely yours,
F. J. L. Blasingame, M.D.
Executive Vice President

Anent the Medical College University of Florida

The following correspondence between Dr. Leo M. Wachtel,* President of the Florida Medical Association, and Dr. George T. Harrell, Dean of the College of Medicine, University of Florida, Gainesville, is published at the request of Dr. Wachtel and upon the consent of Dr. Harrell in an attempt to clarify some questions that have arisen regarding the program and activities of the medical college in Gainesville:

September 13, 1960

George T. Harrell, M.D.
Dean of College of Medicine
University of Florida
Gainesville, Florida

Dear Dr. Harrell:

The practicing physicians of the State of Florida are greatly concerned with the apparent approach to teaching and the direction in which medical students are being directed at the University of Florida Medical School. I hope that you can allay many of our fears, but there are a number of impressions about the Medical School, which if true, are dangerous to the practice of medicine in the future and the care of the health of the people of Florida.

Let me preface my remarks by stating that I have the greatest respect for you as a physician and the highest regard for you personally as a man. While I do not hold you altogether responsible for what appears to be distasteful to the physicians of Florida in the training of young men and women to be doctors, you stand in a position to make corrections.

It was our belief and understanding that the Medical School at Gainesville was established by the Legislature to help provide the citizens of this state with physicians, particularly in those areas where a shortage of adequate professional medical care existed. With this directive in mind, how can

*Your President will appreciate comments from the membership.

these following impressions, inconsistent with this directive, be defended or allowed to continue:

1.) That such a large number of department heads seem to be more concerned with research in a finely divided portion of their particular specialty than in teaching the broad view of their fields of practice;

2.) That because of this interest in research, they are by example directing the students toward research in preference to private practice where they are most needed in Florida;

3.) That seniors are urged to apply for straight rather than rotating internships, the only part of their training where many of them will obtain a knowledge of all of medicine as applied to the whole patient in his total environment, and furthermore, that students are told by department heads that those who take rotating internships elsewhere will be at a disadvantage in being accepted for residency training at Gainesville. Sixteen out of forty graduating seniors have straight internships;

4.) That no visible effort is made to present to students a view of the field of general practice either in formal training or in preceptorship training;

5.) That residents on the house staff are engaged under the title of "fellow" on a stipend and living accommodations far beyond those offered to bona fide residents at other approved hospitals for similar services, and in unfair monetary competition with hospitals within this state;

6.) That, in spite of many good, approved, unfilled internships in the state, only thirteen out of forty members of the first graduating class chose to take internships in Florida, apparently after counseling with members of the teaching staff of the school.

Are these inconsistencies with the conventional methods of practice and the preparation for practice in the State of Florida true? I will anticipate your reply confirming, defending, or rebutting these foregoing impressions. It is not unlikely that this letter and your answer to it will be published in some outlet of the Florida Medical Association.

With warm personal regards, I am

Sincerely,
Leo M. Wachtel, M.D.
President

September 26, 1960

Leo M. Wachtel, M.D.
President
Florida Medical Association
735 Riverside Avenue
Jacksonville 3, Florida

Dear Dr. Wachtel:

Thank you for your letter of September 13, 1960. It is good to know that practicing physicians in the State of Florida are interested in the educational program at the University of Florida College of Medicine. As you know, we have reported through the pages of the *Journal of the Florida Medical Association* each year the philosophy of the school and the progress we have made. We are delighted that you have passed on to us the rumors which have come to your attention. Misinformation and rumor usually stem from a lack of personal, on-the-spot knowledge of fact. It is only by wholehearted cooperation, such as you offer between the officers of the Florida Medical Association and the faculty, that areas of possible misunderstanding can be dispelled and an atmosphere of mutual respect and cordiality maintained. We would welcome the opportunity to have you take the lead and to have other officers of the Association, members of the Board of Governors, or any physician personally pay a visit here to find out at firsthand about our teaching program. We would like you to take as much time as you can so that you might attend teaching exercises, talk with medical students, and evaluate for yourselves, in as much detail as you desire, our approach to teaching. We have been disappointed that you have not been able to come personally before this.

The College of Medicine has not deviated from its announced purpose of training medical students for the practice of Medicine. We feel that the care of the health of the people of Florida will be in good hands in the future, since our clinical training has been based on the accepted principle of teaching by precept and example at the bedside by mature physicians who are recognized as outstanding in their fields. If you will spend a week on our wards, you will find that the heads of our clinical departments are spending more time personally in student instruction on the wards than is true in any other medical school in this country. As you know, our faculty is small in number and you will find that all of the members of our clinical departments are doing a tremendous amount of bedside ward and clinic tutorial teaching.

The role of research in the education process follows two major avenues. As a practicing physician you are aware, in your day-to-day practice, of the powerful new tools which have been placed in your hands for patient care as a result of research. The people of this country have recognized the improvements in patient care resulting from research and have wholeheartedly supported the Congress in its increasing emphasis on support of medical research. The actions of the Congress in increasing the funds available for support of research beyond those requested by the Administra-

tion indicates that in the long range we may expect increasing demands from the public for research and its application to improvement of the general health of the people.

The second avenue is the role of research as a teaching tool. With the rapid growth of medical knowledge resulting from research, it is apparent that any one individual can no longer encompass all aspects of medicine. This fact is equally as true in the physical sciences and other fields as in medicine. In the educational process at professional level one must more and more teach an approach to continuing self-education, the techniques of collection, assimilation, and interpretation of data, and the practice of drawing conclusions from them. Accordingly, we have utilized research as a teaching tool in order to show the developing physician how to train his mind in this intellectual process. I am sure you are aware from an examination of our catalog that a required course in Experimental Medicine is placed in the second year of the curriculum so that it might be used to sum up and integrate knowledge acquired by the student in the basic medical sciences and serve as a bridge to the clinical years of the curriculum. The type of thinking developed in the student is exactly that which the physician employs in the solution of a diagnostic or therapeutic problem in an individual patient seen in his own office. That this approach is grasped by students is illustrated by the fact that not a single student out of the first graduating class has elected to go into a career in research on graduation. Every single student is now in a clinical internship of his own choice.

We have designated a senior faculty member as an official advisor from the medical school faculty to confer with students on the choice of an internship. Students are at perfect liberty, in addition, to consult with any faculty member or physician in practice as they choose. We do not as a policy recommend any given type of internship for all students. We have encouraged all students after their third year to visit hospitals both in and outside of the state to make an on-the-spot, personal evaluation of the educational program offered. We particularly suggest to the students that they talk with interns in the hospital, ask in detail about the formal teaching exercises and the daily informal instruction by the visiting physicians on the staff. The internship from its inception has always been considered an educational experience for the student and has never been intended as a means of achieving patient care in a community. The role of the internship has been under continuous study by organized medicine and by medical educators with a re-examination of its role in relation to undergraduate medical education and residency training. Originally, the internship was planned to give the newly graduated student practical experience at the bedside with an increasing degree of responsibility for decisions on patient care. As clinical clerkships in all medical schools, particularly in the fourth year, have improved, the same type of experience traditionally given during the internship is being given during student years by rotation on all clinical services. Since there are many more approved internships than there are graduating students, the fact that many internships are unfilled is equally true nationwide as in the state. The students will select the type and location of internship on the basis of their own evaluation of its educational advantages.

The first clinical experience of students at the University of Florida is deliberately directed toward the broadest possible general training of the student. At the beginning of the third year all students enter a Basic Clerkship which is taught jointly by all clinical departments. The instructional staff approaches the problem in patients from the point of view of a general physician and not as a specialist. The major outpatient experience is also deliberately pointed in this same direction. As you know, all patients seen here are referred by the family physician. The majority, on their first visit to the Outpatient Department, are seen in the General Clinic, where the student does the detailed, extensive work-up from the broadest possible view. The consultant is drawn from all clinical disciplines and sees the patient as a general physician, not as a specialist. If the opinion of a specialist is needed, one is obtained from another member of the faculty. This general approach on a broad base to both in and outpatient teaching is unusual in medical schools. The student may elect to spend a preceptorship with a practicing physician during five weeks of his fourth year. I am sure you will agree after you have examined the teaching in detail that these techniques are consistent with and point toward preparation for practice on disease as it is seen in the State of Florida.

Members of the house staff in the Teaching Hospital at the University of Florida receive their entire compensation in cash. It has been traditional in the past to furnish many perquisites, in-

cluding room, board, uniforms, and laundry, as you know. Since almost all house officers these days are married and prefer to live with their families, we have adopted the practice which is increasing elsewhere of furnishing nothing as perquisites, permitting the house officer to purchase his meals, and those for his family if he wishes, in the Hospital and to rent an apartment from the University. The apartments are part of those available to any married student in any college of the University. The survey done last year by the Teaching Hospital indicates that our stipends are below those offered by many teaching hospitals in the South. We do have a number of postdoctoral fellows, but I should point out that the majority of these are men who have completed the usual residency training and are in effect junior faculty members, hence their stipends are higher than those of house officers. The number of residencies available at Gainesville is small in relation to the size of our graduating class. Only a small proportion of our graduates can return here for residencies. We have not denied residencies to men because they have taken rotating internships; we have selected them on the basis of their over-all records. It should be pointed out that the first products of our Residency Training Program are now in practice in the State of Florida.

I sincerely trust that I have answered the questions which you have raised. I should be delighted to have your letter and mine reprinted in full in the *Journal of the Florida Medical Association*. Please let me extend again to you and to all members of the Florida Medical Association a most cordial invitation to visit us in Gainesville and to examine in detail, preferably over a period of several days, our teaching methods, educational program, and the attitudes we are attempting to develop in future physicians of Florida.

Cordially,
George T. Harrell, M.D.
Dean

Third Annual Conference
County Medical Society
Presidents and Secretaries
January 14-15, 1961
Hotel Robert Meyer
Jacksonville

LETTER TO THE EDITOR

The following letter is published at the request of Dr. Ralph W. Jack of Miami.

October 7, 1960

Dear Doctor Richardson:

As chairman for this district of the Doctors' Committee for Nixon, it has been my privilege to receive a letter that in my opinion contains information that should be known by all American physicians. With this in mind, I am having this letter copied below.

OFFICE OF THE VICE PRESIDENT
WASHINGTON

September 7, 1960

Dear Doctor:

Our mutual friend, Dr. Elmer Hess, has asked me to send you this note in answer to a request you made to him for a statement as to my attitude toward medical legislation.

Briefly, I opposed the Forand-type legislation, not because I was unsympathetic toward the medical needs of all of our people, including the aged—for I certainly have a concern for their problems, just as I know you do—but chiefly because I am firmly convinced that this type of legislation could lead to the socialization or regimentation of the medical profession, to the detriment of the quality of medical care now furnished our people.

You may be sure that I shall continue to devote my best efforts, by working and consulting with physicians and others concerned with the problem, toward assuring for the American people the best and most scientific medical care available anywhere.

With every good wish,

Sincerely,
S/ Dick Nixon
Richard Nixon

I hope very much that you and your Board will find it possible to publish my entire letter in the next issue of The Journal of the Florida Medical Association.

Sincerely yours,
Ralph W. Jack, M.D.

RWJ:o

PHYSICIAN'S HOBBIES

Painting

A good hobby should bring release from one's regular duties, and ideally could call upon skills the physician has mastered in daily work. Art seems to be ideally suited as a physician's hobby for the following reasons:

Painting is not competitive. The artist works toward a mastery of form and design and color, but he is painting only in competition with his own earlier achievements. He can set his own pace. There is no deadline to meet, and he can leave his painting for days or even a week, then go back and pick it up again just as he left it.

Painting is an inexpensive hobby. Some artists I know start only with paper and pencils.

Painting satisfies a craving for beauty. Most all physicians are surrounded by wonderful compositions for painting, and by learning to transpose these to canvas or board they create even though it may give no one but them a feeling of accomplishment.

Painting can be as private or public as one likes.

It is now estimated that some 50,000,000 people paint, sketch, or sculpt as a hobby, and some do all three. The old idea that one had to be born with talent before he dared pick up a brush has disappeared.

Painting has been recognized, too, as offering release from the tensions of modern life. It is no coincidence that Dwight Eisenhower and Winston Churchill are enthusiastic painters.

Physicians have long been closely associated with art, and even Aesculapius found time to direct the artistic activities of his two daughters, Hygeia and Panacea. Many famous physicians also were able to illustrate their own books, and among them were Richard Bright, Thomas Hodgkin and Lord Lister.

The same skills that make the physician's finger deft can also be trained to wield a brush. The physician-artist starts also with keen observation, trained dexterity and a sympathetic understanding, all of which are important in the essence of art. Sir William Osler had this to say:



An example of the work shown by Dr. Hurt at the Association's Annual Meeting in Jacksonville.

"You cannot practice medicine only, and practice it early and late as so many of us have to do and hope to escape the malign influences of a routine life." Art will help the physician in many ways.

Floyd K. Hurt, M.D.

Note: This is the fourth in a series of discussions of various hobbies being enjoyed by physicians in Florida. These articles are published in the hope that those physicians who do not have a hobby might be encouraged to begin one, and for those who do have a hobby, these remarks may be a source of interest. The Committee on Scientific Work would like to know about your hobby for possible display at the next Annual Meeting. The blank published in this issue of The Journal on page 535 is for your convenience.

OTHERS ARE SAYING

Insurance, Doctors Getting Together

By Arthur M. Browning

Chairman of the Health Insurance Council
And Vice President in Charge of Group Insurance
New York Life Insurance Company

During the past five years a significant improvement has taken place in the relationship between those who provide medical care—our hospitals, physicians, and their organizations—and the insurance companies that provide medical care insurance. Not so long ago any attempt by either one to discuss common problems was too often looked upon with suspicion by the other.

One of the pressing needs furthering this rapport lies in the concern of both regarding rapidly rising costs of medical care. One of the factors contributing to this spiraling of medical costs—inflation—is common to the nation's whole economy, and there is little that either the insurance companies or the medical care providers can do about it. On the other hand, there are other factors about which both can do a great deal.

Most of the insurance companies agree that the chief factors tending to push medical costs upward are these:

Inflation—As in all other parts of our economy, every phase of our medical economy has also suffered from the effects of inflation.

Medical Progress—Never have so much time and funds been placed into the necessary and worthwhile medical research that has already accomplished such wonders in improving man's life expectancy. Such examples as the development of Salk vaccine, the almost complete conquering of tuberculosis, and similar advances have amply justified such research, costly though it is.

Greater Health Consciousness—Americans are now as never before conscious of the need for early treatment and more frequent treatment for ills that are developed. This greater demand for medical care and attention has placed a burden on existing facilities, and upon medical and nursing personnel, with a resultant increase in cost for services and the operation of facilities. It has also increased the cost of health insurance.

Improper Use of Group Medical Care Insurance—This, whether intentional or unintentional, has been a major factor in upping the costs of medical care insurance coverage. With the recognition of this as a serious factor in rising costs, there is much that the insurance industry and the medical profession can do. Also the individuals who have this insurance coverage and pay in part or for all of it, and the employer-policy owners who assume a share of the cost of group medical insurance can help.

The American people want voluntary health care insurance, but they want it at a cost that is within reason. If this is not provided by the insurance companies, they will demand that the Government assume the costs of their health care.

Unfortunately, even within the insurance industry there are some who have remained indifferent to this pressing need.

There are a few who take cover when each new clamor is made for Government payment of medical costs. They would be serving the public far better if they would forcefully illustrate the tremendous strides that have been made in the past decade in placing more and more people under the cover of voluntary Prepaid Health Insurance.

Basic Concept

There are others within our industry who have strayed from the basic insurance concept of "indemnity against loss" to "incentive for gain." I am referring to the "liberality" race that some insurance companies have engaged in, to see who can add the most liberal provisions to their contracts without due regard to the basic actuarial laws of insurance.

And there is still a third group among us who blindly refuse to admit the realities of the relationship between economics and medicine, and who

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always insist that "we have time" even when the proponents of Government control of health insurance have lined up their statisticians, propagandists and crusaders. The truth of the matter is that the time for action is here now, as witness the repeated bills and proposals that are brought before Congress.

Many of our companies have experienced a precariously high loss ratio in the medical care insurance operations. This of course manifested itself in a general increase in our Standard Rate levels. With inflation causing an annual increase of from 56 per cent to 7 per cent in hospital expenses, we soon found that our rate levels which were adequate in 1952 could no longer support the level of benefits we offer. Since all other costs of living were undergoing this same inflationary experience, the rise was generally understandable.

Coupled with this was a public demand for first dollar coverage. In health insurance parlance, first dollar refers to the first costs that are incurred in any illness, while last dollar refers to the later costs when an illness becomes catastrophic in total cost of treatment. Obviously most visits to a doctor or hospital are of brief duration and fall into the first dollar category. But for an insurance contract to indemnify each of these minor costs, with consequent administrative expenses, imposes greater insurance costs and higher premium. It is for this reason that many contracts carry a deductible factor.

Plans of insurance have taken three basic directions. Earliest were the basic plans of hospital surgical and medical coverage. From these we went into Supplementary Major Medical coverage which supplemented the basic coverages in order to cover catastrophic medical costs. Then we went into comprehensive major medical which replaces the other two—the basic coverage and the supplemental or catastrophic coverage. Like the supplementary, such contracts include a deductible and a coinsurance factor (usually 20 per cent—25 per cent), applied after the deductible, with a ceiling of from $5,000 to $10,000 over-all coverage.

This broader coverage placed a greater responsibility upon the medical profession to understand the economic relationship of insurance and medical care.

One heavy demand for medical welfare benefits has come through collective bargaining for more complete coverage to all economic levels. Out of labor-management meeting came requests

Announcing The Twenty-Fourth Annual Meeting
of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters — Roosevelt Hotel
March 6, 7, 8, 9, 1961

GUEST SPEAKERS

Arthur S. Keats, M.D., Houston, Tex.
Anesthesiology
Robert R. Kierland, M.D., Rochester, Minn.
Dermatology
Frank B. McGlone, M.D., Denver, Colo.
Gastroenterology
Thomas T. Jones, M.D., Durham, N. C.
General Practice
John C. Ullery, M.D., Columbus, Ohio
Gynecology
Walter Lyon Bloom, M.D., Atlanta, Ga.
Internal Medicine
Herman J. Moersch, M.D., Rochester, Minn.
Internal Medicine
William A. Sodeman, M.D., Philadelphia, Pa.
Internal Medicine
Jack A. Pritchard, M.D., Dallas, Tex.
Obstetrics
Daniel Snydacker, M.D., Chicago, Ill.
Ophthalmology
Leon L. Wiltse, M.D., Long Beach, Calif.
Orthopedic Surgery
Sam E. Roberts, M.D., Kansas City, Mo.
Otolaryngology
S. E. Gould, M.D., Eloise, Mich.
Pathology
Stuart S. Stevenson, M.D., Jersey City, N. J.
Pediatrics
Harry E. Bacon, M.D., Philadelphia, Pa.
Proctology
Albert Jutras, M.D., Montreal, Quebec, Can.
Radiology
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For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

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for broader plans of health insurance coverage. As a result, new money was pumped into the medical economy. Inflation breeds upon the introduction of new and heretofore untapped monetary sources. Many recipients of health insurance benefits failed to realize that this money was not coming from some magic well at the insurance home office, but rather from a fund created by their premium dollars.

It is a responsibility of the insurance industry to see that these programs continue and are extended. Already several employers with group contracts have pursued similar programs among their own employes. Nor has the medical profession failed to play its part in this. As evidence, the American Medical Association has recently released for publication a brochure entitled "Let's Use, Not Abuse Health Insurance." Copies of this may be obtained by writing to the association at 535 North Dearborn Street, Chicago, Ill.

The Journal of Commerce
New York, June 17, 1960

BLUE  **SHIELD**

New Federal Programs For Health Care

Steadily, inexorably the federal government moves into new areas of health care. As a result of legislation passed during the last session of the Congress and signed into a law by the President, two new programs are to be added to the ever increasing encroachment. One of these laws will provide health care benefits, on a share-the-cost basis, for federal employees who were retired prior to July 1, 1960, similar but not identical to those now available under the Federal Employee Health Benefits Act for those retiring now and in the future. The other will provide medical care for needy persons over 65 years of age who are either currently receiving public assistance, or whose income and resources are insufficient to meet expenses due to illness.

With inclusion in the Health Benefits Act of 1959 of those federal employees who retire after participating in this program, it became obvious that some provision should be made to provide similar advantages to those on retirement when the program went into effect.

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(Florida National Bank of Jacksonville)

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c) 35% in a Pension Trust life contract underwritten by Pan-American Life Insurance Company

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GUARANTEED COST OF TOMORROW'S ANNUITY AT TODAY'S RATES

GUARANTEED ISSUE LIFE INSURANCE

How to Enroll in the Plan

USE APPLICATION ON REVERSE SIDE OF THIS PAGE

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Edward Jelks, M.D., Jacksonville
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John D. Milton, M.D., Miami
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Trustee
Florida National Bank of Jacksonville

Life Underwriter
Pan-American Life Insurance Company
James E. Devaney, Consultant

Please complete and mail to:

FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST
P. O. Box 2411, Jacksonville 3, Florida
APPLICATION FOR PARTICIPATION

TO: The Florida National Bank of Jacksonville as Trustee
of the Florida Medical Association Investment Trust

In consideration of your acting as Trustee, I agree to participate in Division I — "Restricted Retirement Trust of the Florida Medical Association Investment Trust" as now constituted and as may be modified or amended, and subject to the rules and regulations as may be adopted by the Florida Medical Association Investment Trust Committee.

No insurance or insurance benefits or any obligation or agreement by the Association or the Trustee to procure or make effective insurance or insurance benefits under said plan shall be effective or enforceable except in accordance with the terms of and as of the effective date of any written policy when issued pursuant to and upon acceptance by the insurance company, of my written application for insurance on form submitted hereafter by the insurance company.

It is my intention to contribute to the Trustee funds or assets acceptable to the Trustee in at least the minimum annual amount specified by the FMA Investment Trust Committee.

I agree that contributions made to the Trustee shall be placed to my credit on the books of the Trustee.

I reserve the right to withdraw my participation and my assets at the end of any quarterly period, upon 30 days' written notice to the Trustee prior to the end of such quarterly period.

I plan to deposit annually $ _____.

Name _____ M. D.

Address _____

City _____

Date of Birth _____

Date _____

The above mentioned physician is a member in good standing of the Florida Medical Association.

By _____
Florida Medical Association

For copies of the Trust Instrument, Rules and Regulations or additional information—

Contact

FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST COMMITTEE
P. O. Box 2411
Jacksonville 3, Florida

Disregarding advice from Blue Cross–Blue Shield and the insurance industry, the Congress elected to segregate these older persons into a group by themselves, a group with continuously diminishing numbers and a constantly increasing average age. Each eligible retiree will have a choice between one government-wide plan—the carrier for which is not yet determined—and any acceptable health insurance program in which he may already be participating. The program is scheduled to become effective July 1, 1961.

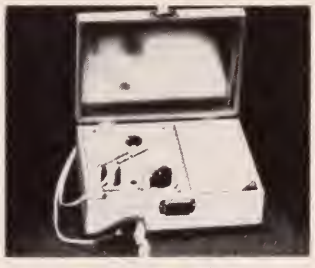
Although the legislation providing health care benefits for the aged was endorsed and vigorously supported by the American Medical Association, and although it is quite removed from the Forand type of proposal, nevertheless it puts the federal government deeper into the business of medical care. The new program, to be administered under the public assistance section of the social security act, will provide additional funds, on a state matching basis, for persons over age 65 who are presently receiving assistance through a state welfare program. In addition, it will join the states in a liberal matching formula for meeting medical expenses of an estimated 10 million older persons who are not on relief, but whose incomes and resources are inadequate to pay these additional bills.

By law, the additional aid for the aged can begin as early as Oct. 1, 1960. How soon it can be made effective depends upon the individual states convincing the Secretary of the Department of Health, Education, and Welfare that they have established a workable system within the requirements of the law and the Department, and that they have provided adequate matching funds. The proportionate amount is to be determined by the matching formula and will vary inversely with the state's per capita income. Estimated first year cost for the nation is about $262 million. Of this, the states are expected to provide some $60 million. In Florida it is estimated that during the first year the state would need to provide approximately $199,000 to match the federal government's contribution of $4.7 million.

Federal Employee Program Enrollment

Latest figures at present time reveal that a nationwide total of 937,634 subscribers and 2,833,061 participants are enrolled in the Service Benefit Plan of the Federal Employees Health Benefits Program. In Florida, enrollment of Federal employees (by residence) shows a total of 19,026 contracts, covering 62,485 participants (subscribers and dependents).

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STATE NEWS ITEMS

A three day Sectional Meeting of the American College of Surgeons will be held January 16-18 in the Dinkler-Tutwiler Hotel at Birmingham, Ala. Dr. Ashbel C. Williams of Jacksonville will serve as presiding officer of the discussion for the first afternoon session on early diagnosis and management of cancer.

Dr. Donald F. Marion of Miami participated in the program of the 111th annual meeting of the Indiana State Medical Association held October 2-5 at French Lick, Ind. Dr. Marion was a member of the panel which discussed the topic "Surgical Diseases of the GI Tract."

Dr. G. Dekle Taylor of Jacksonville presented his new motion picture entitled "Man Returns to the Sea" at the Eighth Congress of the Pan Pacific Surgical Association held September 27-October 5 at Honolulu, Hawaii. The picture was shown by Dr. Taylor at the meeting of the American Academy of Ophthalmology and Otolaryngology held the week of October 9 in Chicago.

Dr. DeWitt C. Daughtry of Miami and Drs. Mark W. Wolcott, William A. Shaver, George L. Baum and Ira N. Rosenstein of Coral Gables appeared on the program of the 17th Annual Meeting of the Southern Chapter, American College of Chest Physicians held at St. Louis, Mo., October 30-31. Dr. Daughtry presented a paper entitled "Diagnosis and Management of Mediastinal Tumors." Drs. Wolcott and Shaver were co-authors of the presentation on "Spontaneous Pneumothorax," and Drs. Baum and Rosenstein co-authors of "Experiences with Emivan, A New Respiratory Stimulant."

Dr. Franklin J. Evans of Coral Gables, president of the Dade County Medical Association, was guest speaker at a recent meeting of the Miami Association of Accident and Health Underwriters.

A grant of $21,638 from the National Foundation has been awarded the University of Florida College of Medicine for research in drugs possibly useful in the treatment of hydrocephalus. The work will be conducted by Dr. Thomas H.

(Continued on page 568)

DO YOU HAVE . . .
A PAPER – OR SCIENTIFIC EXHIBIT

You would like to present at the Florida Medical Association's Eighty-Seventh Annual Meeting, May 25-28, 1961, Bal Harbour?

Scientific Paper—An abstract of 50 words should accompany application

Exhibit—With application, send resume of subject and photograph or sketch

Deadline for abstracts is November 15

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Committee on Scientific Work
P. O. Box 2411 Jacksonville 3, Florida



in infectious disease[17,22,5]
in arthritis[18,19,2]
in hepatic disease[2,3,4,]
in malabsorption syndrome[1,2,]
in degenerative disease[6,7,19,2]
in cardiac disease[23,28,29,3]
in dermatitis[24]
in peptic ulcer[8,2]
in neuroses & psychiatric disorders[2]
in diabetes mellitus[31,32,3]
in alcoholism[9,11,33,3]
in ulcerative colitis[10,14]
in osteoporosis[13,1]
in pancreatitis
in female climacteric[12]

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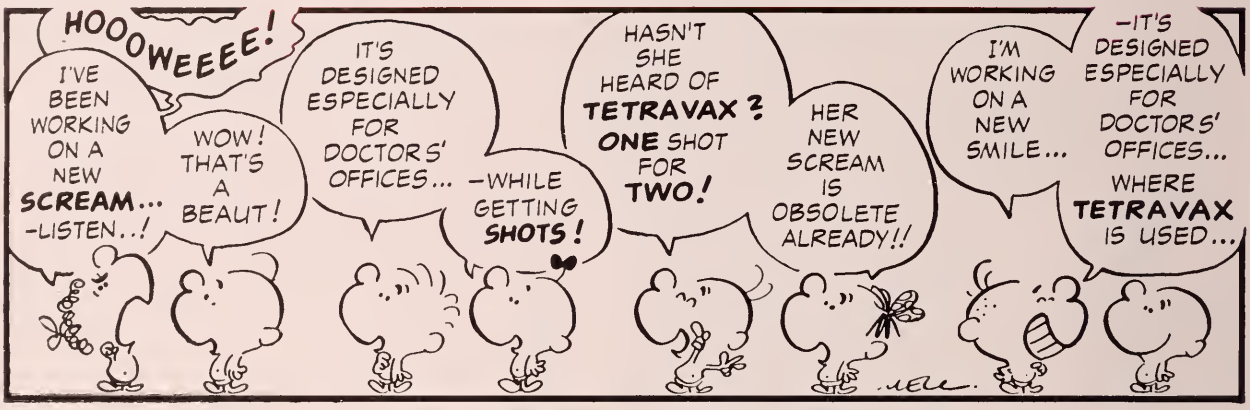
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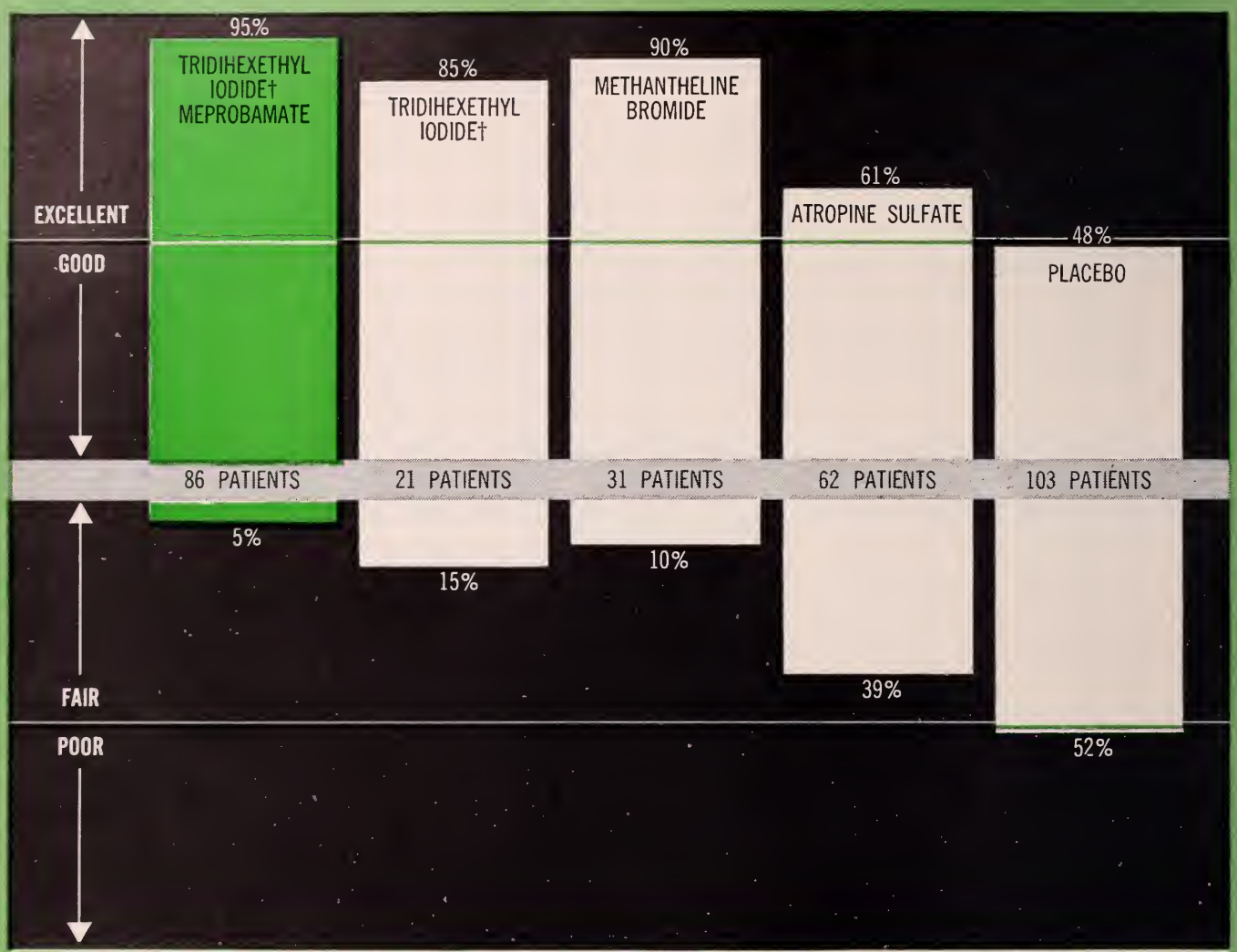
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Dosage: Average oral adult dose is 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

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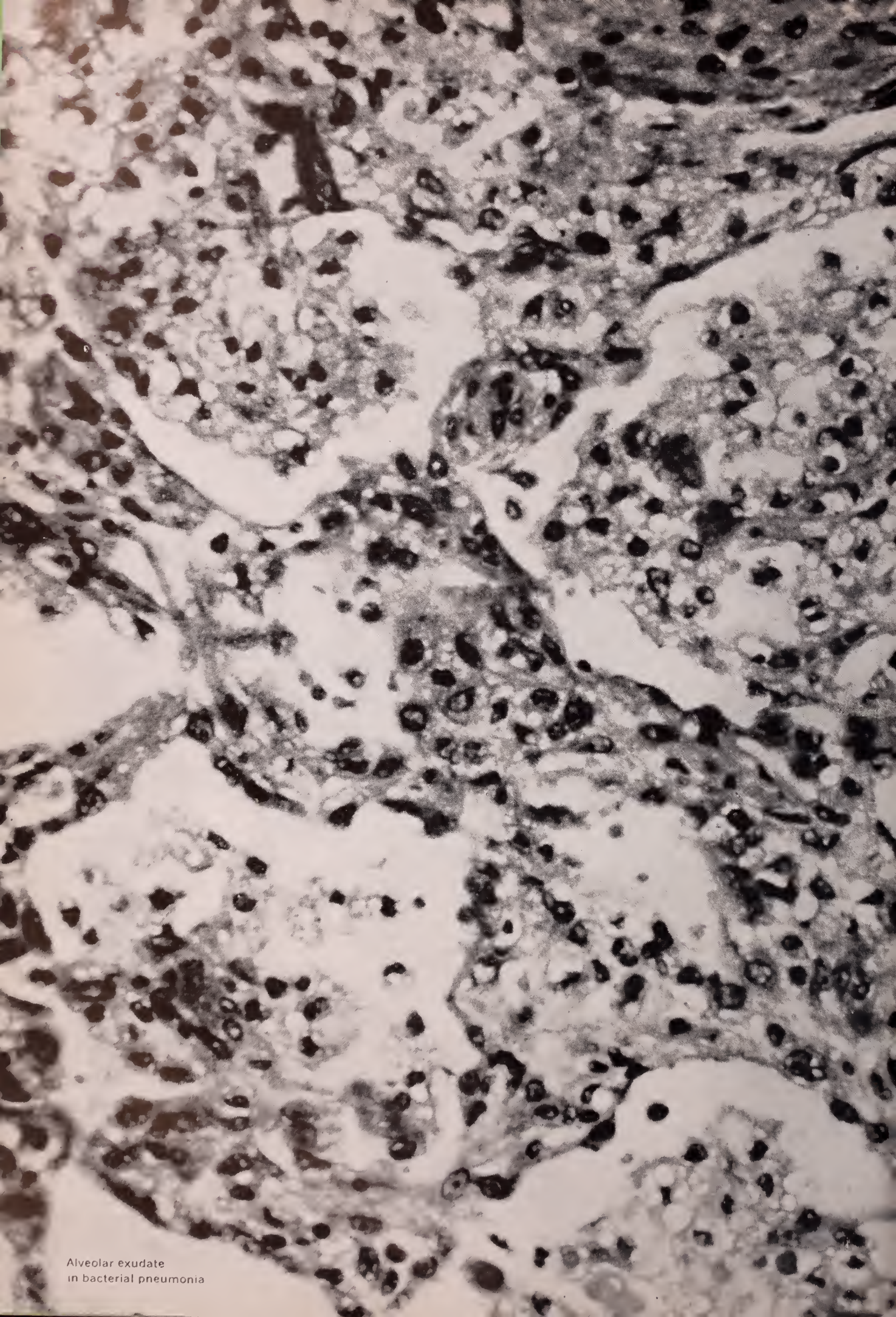
SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

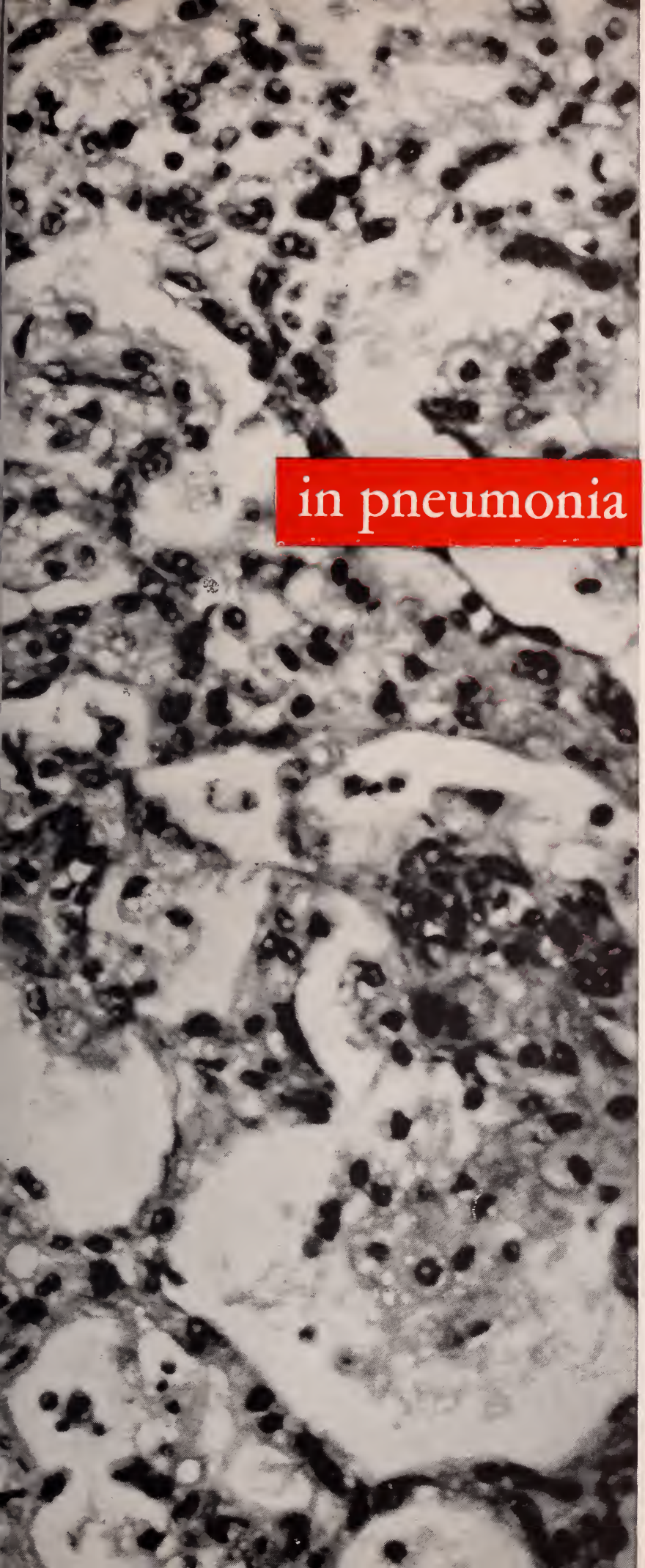
†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

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Panalba*

your broad-spectrum antibiotic of *first* resort

(Continued from page 560)

Maren, Professor of Pharmacology and Therapeutics, assisted by Dr. Mary Jelks, Research Associate in Pharmacology and Pediatrics.

Dr. Thomas D. Weaver of Clermont, secretary of the Lake County Medical Society, was principal speaker at a recent meeting of the Lions Club there.

A grant of $620.000 has been provided the University of Miami School of Medicine by the National Institutes of Health for research in the field of cellular aging. Dr. Gordon C. Ring, Professor of Physiology, and Dr. George T. Lewis, Professor of Biochemistry, will be engaged in the new research project.

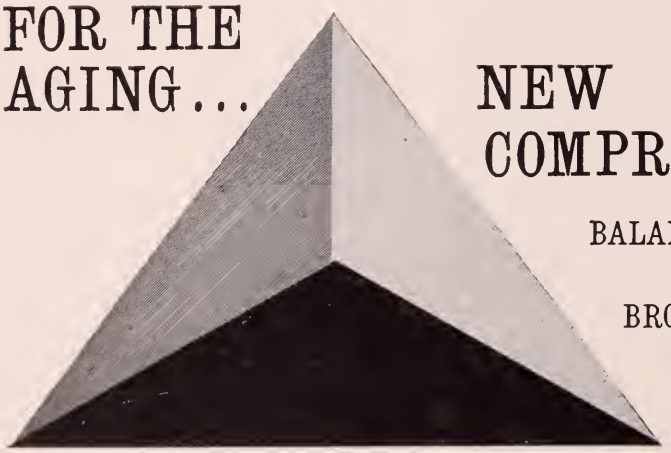
Florida physicians participating in the Thirty-Second Annual Convention of the Florida Public Health Association held at Miami Beach October 13-15 included Drs. William R. Stinger, Turner E. Cato, John D. Milton, M. Eugene Flipse and A. Lester Stepner of Miami; Dr. Franklin J. Evans of Coral Gables; Drs. Albert V. Hardy and Simon D. Doff of Jacksonville; Drs. Charles H. Carter and John D. Ainslie of Gainesville; Dr. William M. C. Wilhoit of Pensacola, and Dr. Clarence L. Brumback of West Palm Beach.

Dr. George F. Smith, Instructor in Pediatrics at the University of Miami School of Medicine, has been assigned by the World Health Organization to make a special study of the care of mentally retarded children in Denmark, the Netherlands, West Germany, Switzerland, England and possibly Russia.

Dr. Turner Z. Cason of Jacksonville was guest speaker at recent rededication ceremonies formally changing the name of the Nassau General Hospital at Fernandina to Humphreys Memorial Hospital in honor of the late Dr. D. G. Humphreys.

Florida physicians participating in the program of the 1960 Annual Meeting of the Florida Division of the American Cancer Society held at Fort Lauderdale October 7-9 included Dr. Leo M. Wachtel of Jacksonville, President of the Florida Medical Association; Dr. Joseph J. Zavertnik of Miami, president of the Florida Divi-

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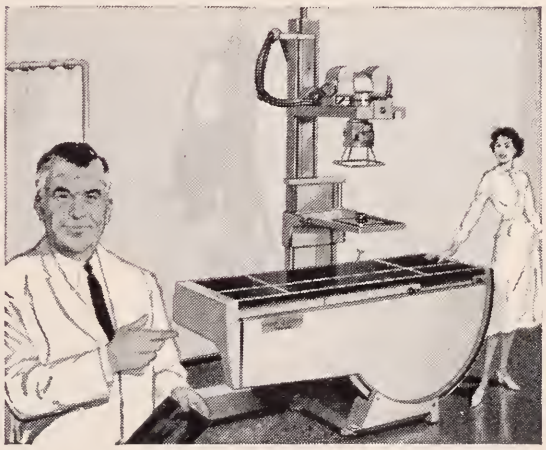
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sion of the Society, and Drs. Elmer B. Campbell Jr. of St. Petersburg; W. Ansell Derrick of Orlando; Dale E. York of Pensacola; Willard F. Ande of West Palm Beach; Margaret E. Waid of Gainesville; Hugh G. Reaves of Sarasota; Ashbel C. Williams of Jacksonville and Earl E. Wilkison of Tallahassee.

Faculty members of the University of Miami School of Medicine who appeared on the program "What's New in Cancer Therapy" presented by the Florida Division, American Cancer Society, in cooperation with the School of Medicine at Fort Lauderdale October 8 were Dr. John J. Fomon, Associate Professor of Surgery; Dr. George P. Daurelle, Associate Professor of Radiology; Dr. Daniel S. Martin, Associate Professor of Surgery; Dr. Ulfar Jonsson, Assistant Professor of Medicine; Dr. Denis Cavanaugh, Assistant Professor of Obstetrics and Gynecology; Dr. George R. Prout Jr., Associate Professor of Surgery and Chairman of the Division of Urology, and Dr. Frank T. Kurzweg, Professor of Surgery.

Dr. Paul V. Reinartz, Medical Director of the Prudential Life Insurance Co. Home Office in Jacksonville, has been made an Executive Medical Director of the company and will return to the Corporate Home Office in Newark, N. J., in October.

Dr. Harold O. Hallstrand of Miami has been appointed Regent for the State of Florida of the the United States Section, International College of Surgeons. He is also a member of the Board of Governors and was previously a vice president. Dr. Hallstrand participated in the program of the combined meeting of the University of Manitoba School of Medicine and the Canadian and United States Sections of the International College of Surgeons held at Winnipeg, Manitoba, Canada, September 27-29.

Drs. Jacob A. Glassman and Jerome Benson of Miami Beach attended the meeting of the American College of Surgeons held in San Francisco October 10-14 and presented their scientific exhibit "The Patho-Physiologic Effects of Crushing Intestinal Instruments with a Presentation of a New Concept in Non-Crushing Instruments." Research culminating in the concept portrayed by the exhibit was developed at the Mount Sinai Hospital of Greater Miami and at the University of Miami School of Medicine.

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Dr. Clifford C. Snyder of Miami has been re-elected assistant secretary of the American Society of Plastic and Reconstructive Surgery.

Florida physicians presenting papers at the Fall Meeting of the Florida Orthopedic Society held October 15-16 at Boca Raton included Drs. Augusto Sarmiento of Miami; Joseph C. Flynn and Joseph G. Matthews of Orlando; Davis S. Boling of Tampa; Elwin G. Neal of Miami Shores; Richard A. Worsham of Jacksonville, and James L. West Jr. and Irwin S. Leinbach of St. Petersburg.

Dr. Hawley H. Seiler of Tampa has been elected president of the Hillsborough County Unit of the American Cancer Society.

Dr. Lorant Forizs of Tarpon Springs was one of the principal speakers at the Southern Psychiatric Conference held October 2-4 at Virginia Beach, Va.

Dr. D. Ralph Millard Jr. of Miami has been appointed Honorary Consultant in plastic surgery to the Government of Jamaica.

COMPONENT SOCIETY NOTES

Broward

Col. George M. Knouf of Patrick Air Force Base was principal speaker at the September meeting of the Broward County Medical Association. The title of his address was "Medical Aspects of the Missile Program."

Duval

Dr. William C. Thomas Jr. of Gainesville, Associate Professor of Medicine at the College of Medicine, University of Florida, discussed "Calcium Metabolism" at the October meeting of the Duval County Medical Society.

Lake

Dr. Charles H. Carter of Orlando, Medical Director of Sunland Training Center, was principal speaker at the September meeting of the Lake County Medical Society held at Leesburg.

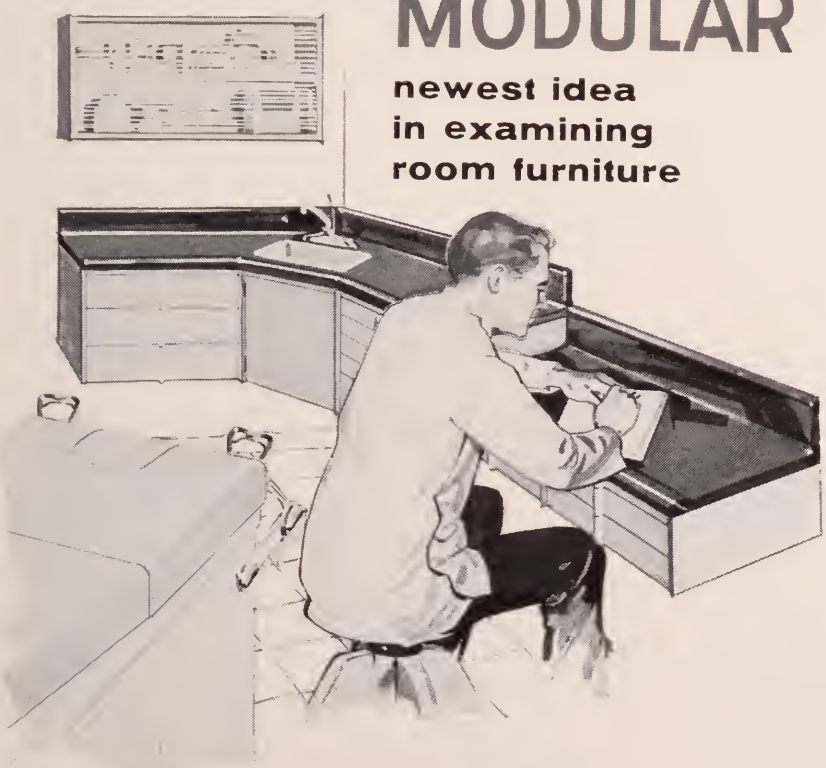
Polk

Dr. Jere W. Annis of Lakeland addressed members of the Polk County Medical Association at their October meeting held at the Lakeland Yacht and Country Club. Dr. Annis' subject was "Blue Shield." Dr. Edward R. Annis of Miami was principal speaker at the Association's September meeting also held in Lakeland.

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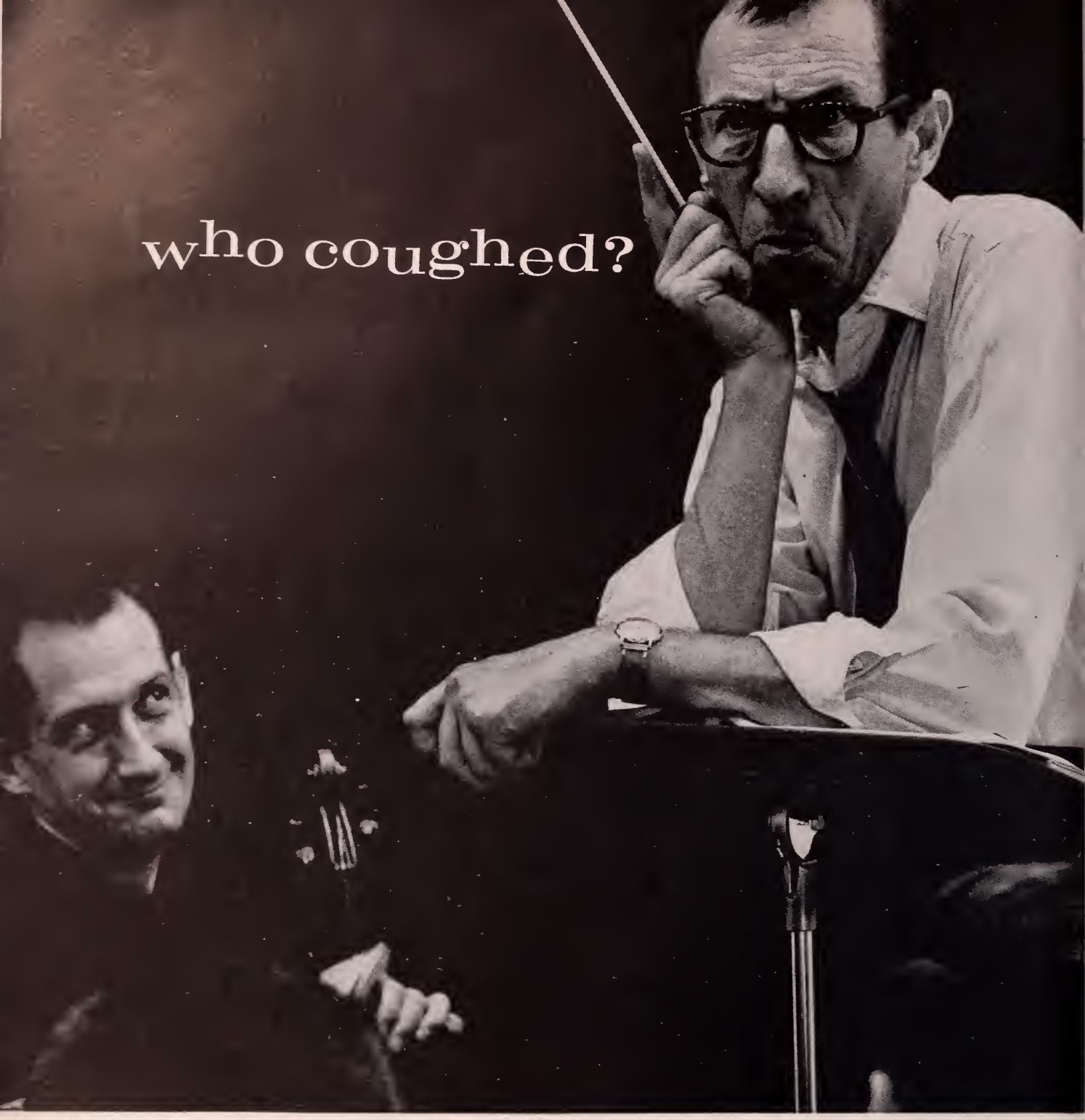
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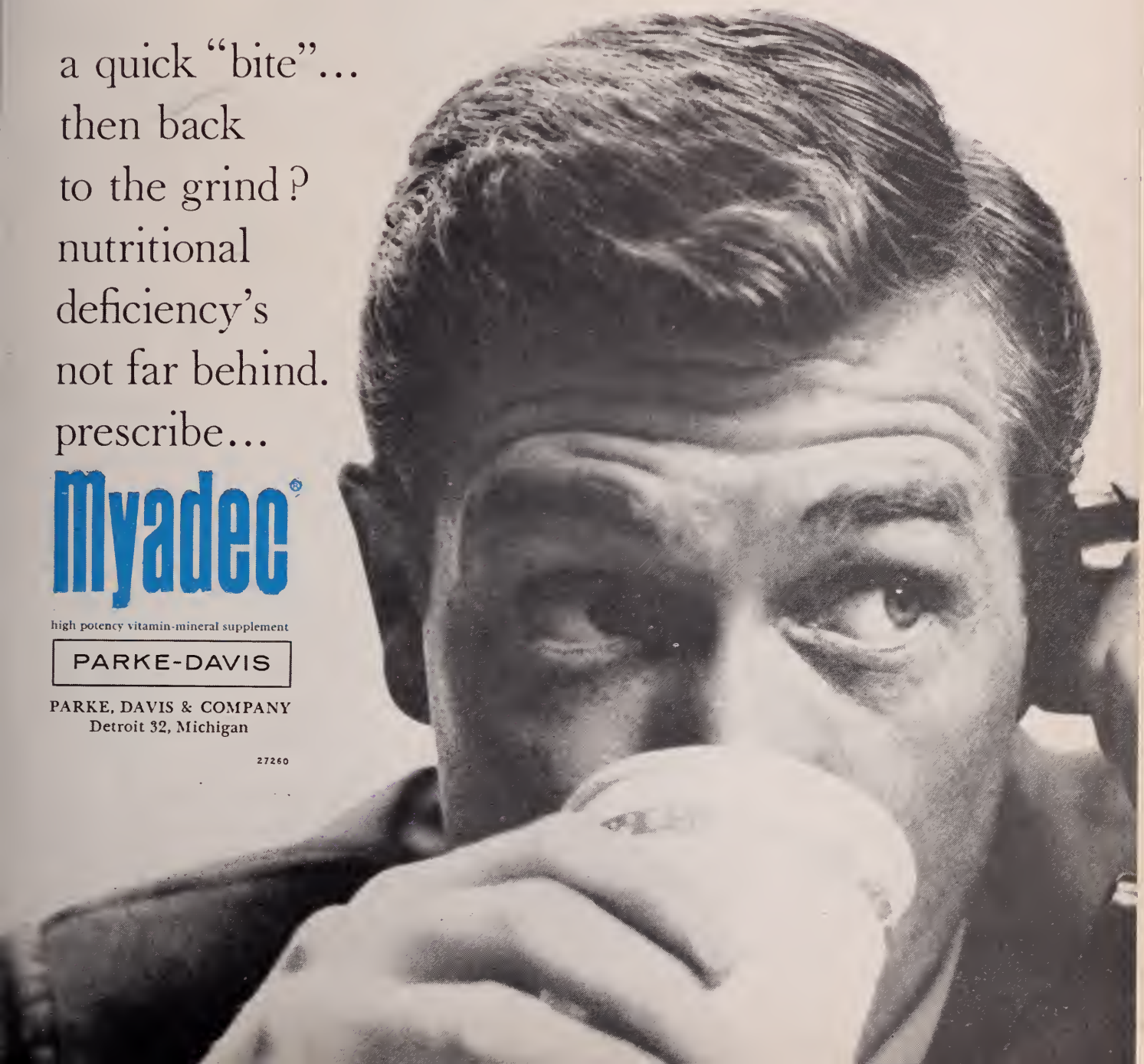
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Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

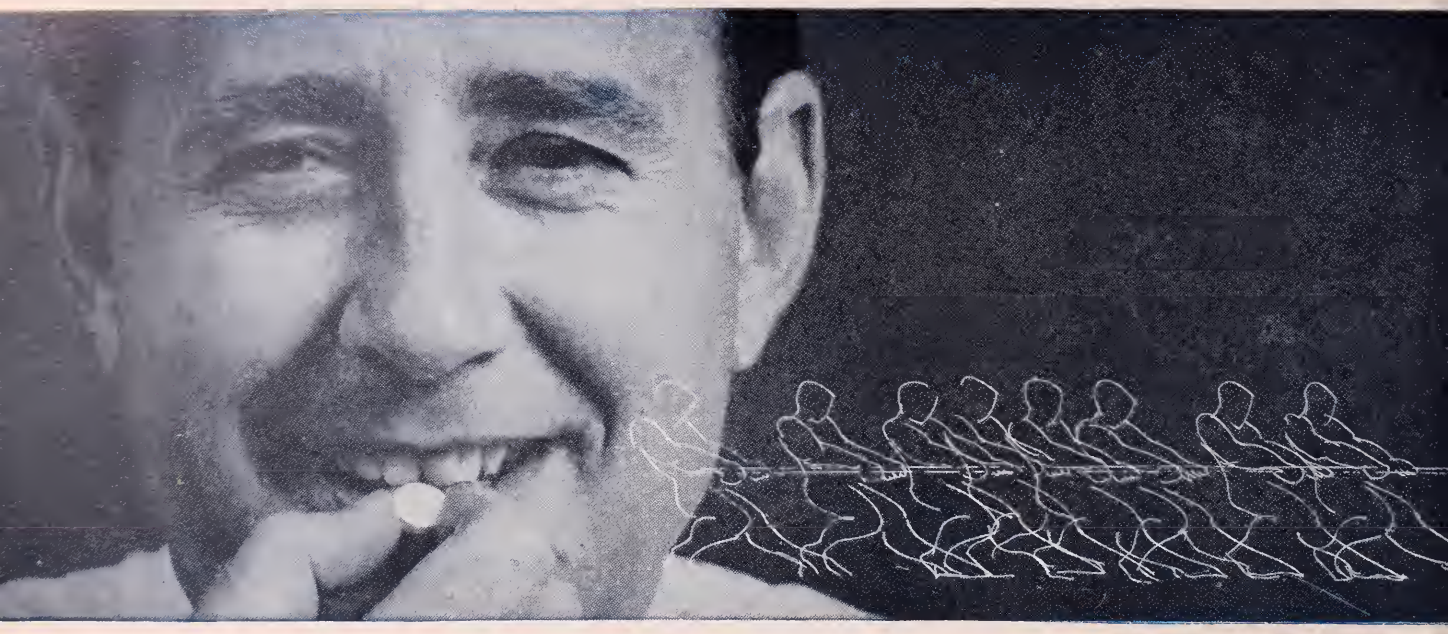
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References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

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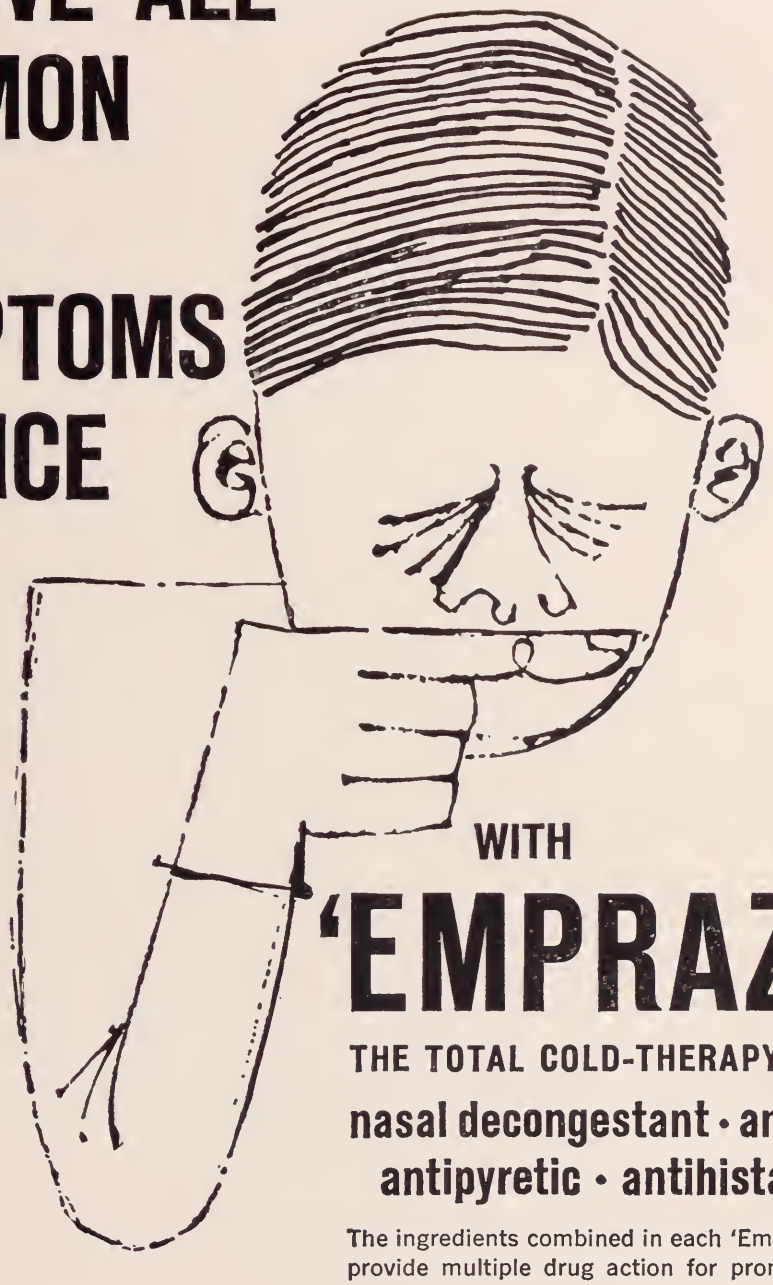
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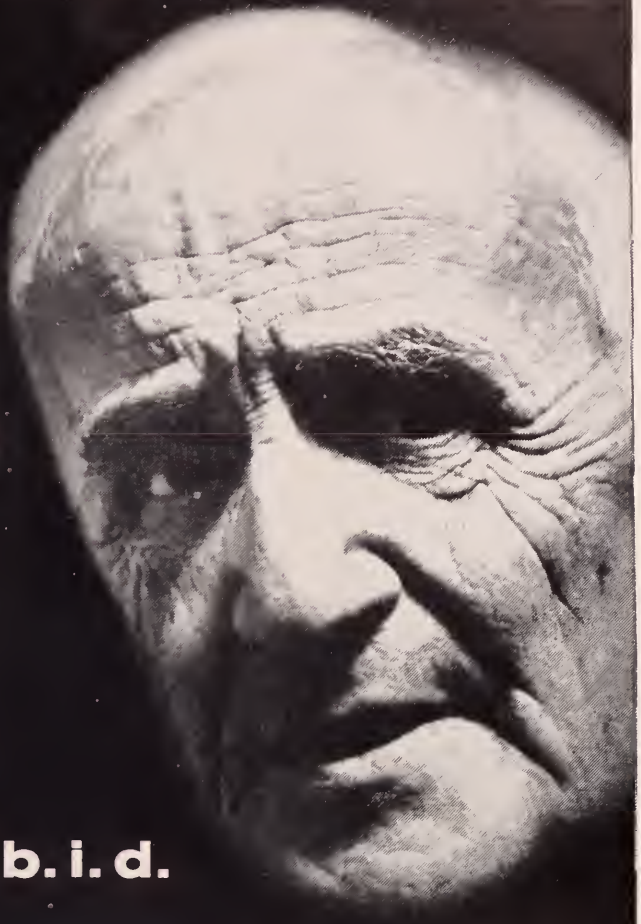
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Kills pain



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For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

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94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

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87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects —in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

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You see an improvement within a few days Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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benzthiazide

NaClex®

a new molecule with an unsurpassed faculty for salt excretion

A. H. Robins announces NaClex, a potent, oral, nonmercurial diuretic. NaClex is a new molecule, designated benzthiazide. Its unique chemical structure produces a "pronounced increase in diuretic potency"[1] over many older diuretics. NaClex also has antihypertensive properties, and it enhances the activity of other antihypertensive drugs.



in diuresis

salt removal is still the fundamental objective

As salt goes, so goes edema

A fundamental principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[2] New NaClex helps reduce edema through the application of this basic principle.

Apparently functioning in the proximal renal tubules, NaClex strictly limits the reabsorption of sodium and chloride ions. To maintain the essential, subtle balance between salt and water, the body's homeostatic mechanism reponds to this loss of ions by allowing an increased excretion of excessive extracellular water. Thus the NaClex-induced removal of salt leads directly to the reduction of edema.

How potent is benzthiazide?

Compared tablet for tablet with oral diuretics now available, NaClex is unsurpassed in potency. Milligram for milligram, it has achieved optimum diuresis in pharmacologic studies at 1/20 the dose required for chlorothiazide.

What are the major diuretic indications for NaClex?

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with conditions such as congestive heart failure, cirrhosis of the liver, chronic renal diseases (including nephrosis), premenstrual tension, toxemia of pregnancy, and obesity. Edema of local origin and that caused by steroids may also benefit.

To what extent is NaClex useful in hypertension?

NaClex has definite antihypertensive properties, and may be used alone in mild hypertension. In severer cases it may be used with other antihypertensive drugs, potentiating them and permitting their use at lower dosage. In hypertension with associated water retention, NaClex is of twofold value. It may be prescribed for congestive heart failure as an ancillary measure to digitalis.

Is potassium excretion a problem with NaClex?

In short-term therapy, excessive potassium excretion is unlikely. In the effective dose range, potassium loss varies from 1/6 to 1/2 that of sodium. Naturally, the ratio of these ions depends on the rate at which excess sodium stores are depleted, and whether salt intake is restricted.

Can NaClex and mercurials be given concurrently?

Yes. When so employed, NaClex may increase the efficacy of mercurials. But NaClex alone is often effective enough to eliminate the need for parenteral mercurial administration. Also, NaClex may be effective in cases when mercurials are not.

Supply: Available in yellow, scored 50 mg. tablets.

References: 1. Ford, R. V., Cur. Therap. Res., 2:51, 1960. 2. Pitts, R. F., Am. J. Med., 24:745, 1958.

For complete dosage schedules, precautions, or other information about new NaClex, please consult basic literature, package insert, or your local Robins representative, or write to A. H. Robins Co., Inc., Richmond, Va.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

True S-U-S-T-A-I-N-E-D Action in Steroid Therapy

PREDLON™
PELSULES*

prednisolone

Only 2 Pelsules Daily
Maintenance Dose

- Better therapeutic response
- Reduced daily dosage
- Fewer side effects
- Greater safety, convenience and economy



Now, for the first time, the benefits of steroid therapy are enhanced by sustained release PREDLON PELSULES.

USES: Rheumatoid arthritis, disseminated lupus erythematosus, allergic diseases, and other conditions where the use of steroids is indicated.

SUPPLY: PREDLON 5 mg. is available in bottles of 30 and 100 Pelsules.

DRUG Specialties INC.

Samples and Literature on request

WINSTON-SALEM 1, NORTH CAROLINA

*trademark for timed disintegration capsules

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE



attains
sustains
retains

extra
antibiotic
activity

extra-activity...promptly attained

DECLOMYCIN Demethylchlortetracycline attains —usually within two hours—blood levels more than adequate to suppress susceptible pathogens. These levels are attained in tissues and body fluids on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. With other tetracyclines, the average, effective, adult daily dose is 1 Gm. With DECLOMYCIN Demethylchlortetracycline, it is only 600 mg.



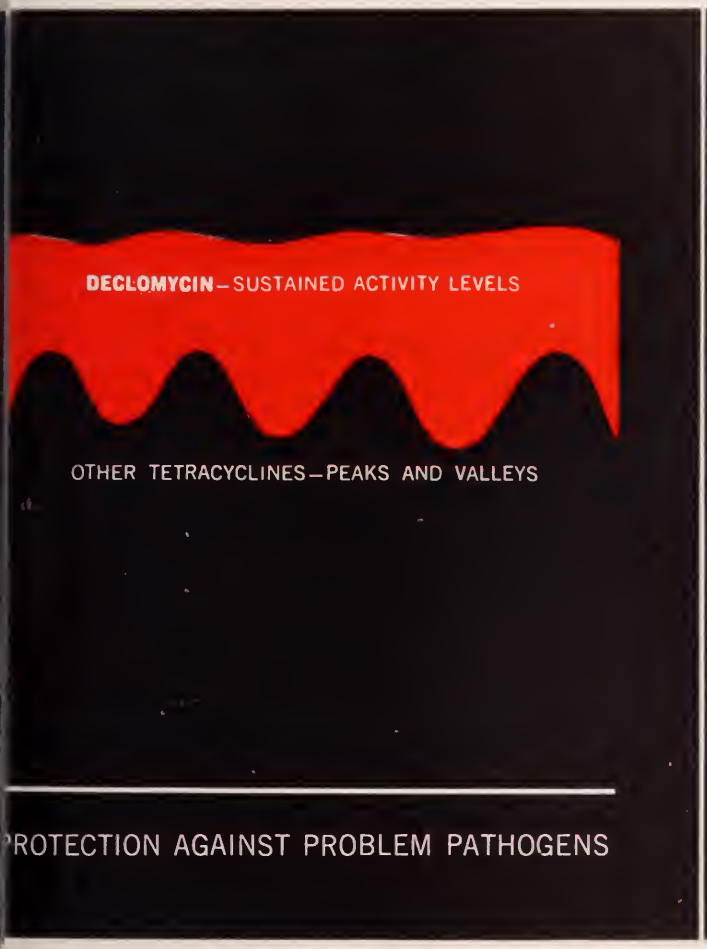
DECLO

evenly sustained

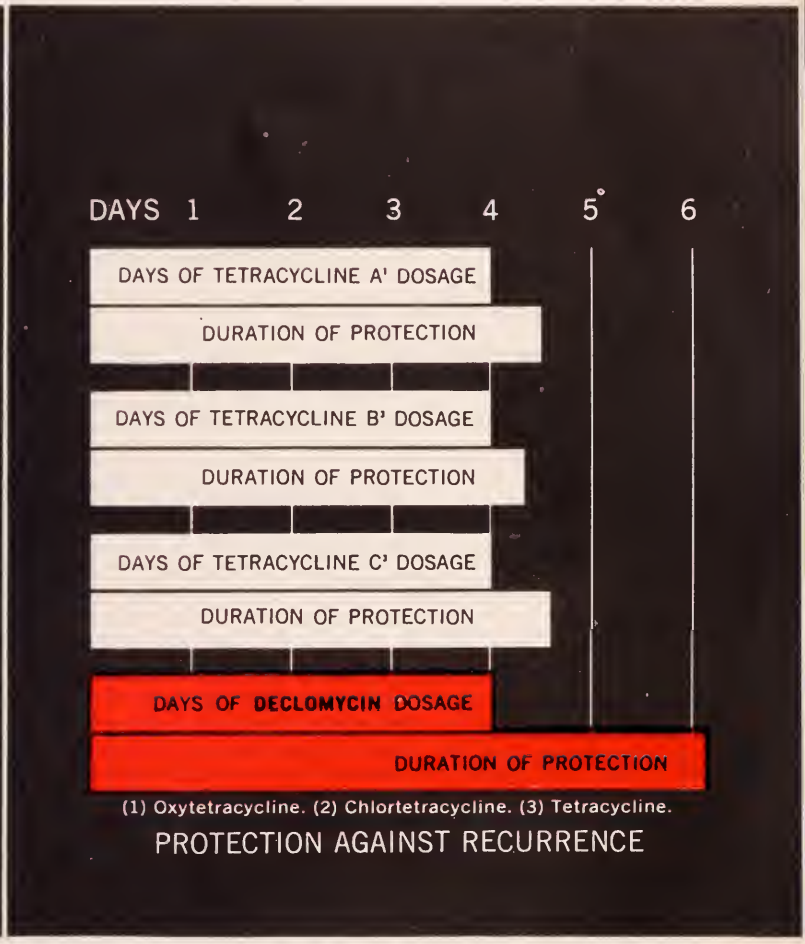
ECLOMYCIN Demethylchlortetracycline sus-ains, through the entire therapeutic course, the igh activity levels needed to control the primary nfective process and to check the onset of a com-licating secondary infection at the original—or at nother—site. This combined therapeutic action s sustained, in most instances, without the ronounced hour-to-hour, dose-to-dose, peak-nd-valley fluctuations in activity levels which haracterize other tetracyclines.

long retained

DECLOMYCIN Demethylchlortetracycline retains significant activity levels, up to 48 hours after the last dose is given. At least a full, extra day of positive antibacterial action may thus be confidently expected. One capsule four times a day, for the average adult in the average infection, is the same as with other tetracyclines—but the **total** dosage is lower and the duration of anti-infective action is longer.



ROTECTION AGAINST PROBLEM PATHOGENS



(1) Oxytetracycline. (2) Chlortetracycline. (3) Tetracycline.

PROTECTION AGAINST RECURRENCE

MYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

- higher activity/intake ratio—positive antibacterial action
- sustained activity levels—protection against problem pathogens
- up to two extra days' activity—protection against recurrence

CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—**1** capsule four times daily. Severe infections—Initial dose of 2 capsules, then **1** capsule every six hours.
PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.
SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS: As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

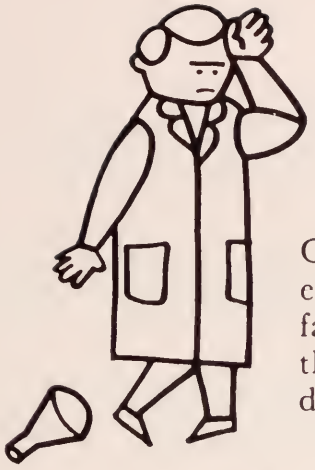
Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

for the added measure of protection in clinical practice

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



One pharmaceutical research executive points up the importance of failures as guideposts to success in the search for new or improved drugs when he says:

"Failure is our most important product."

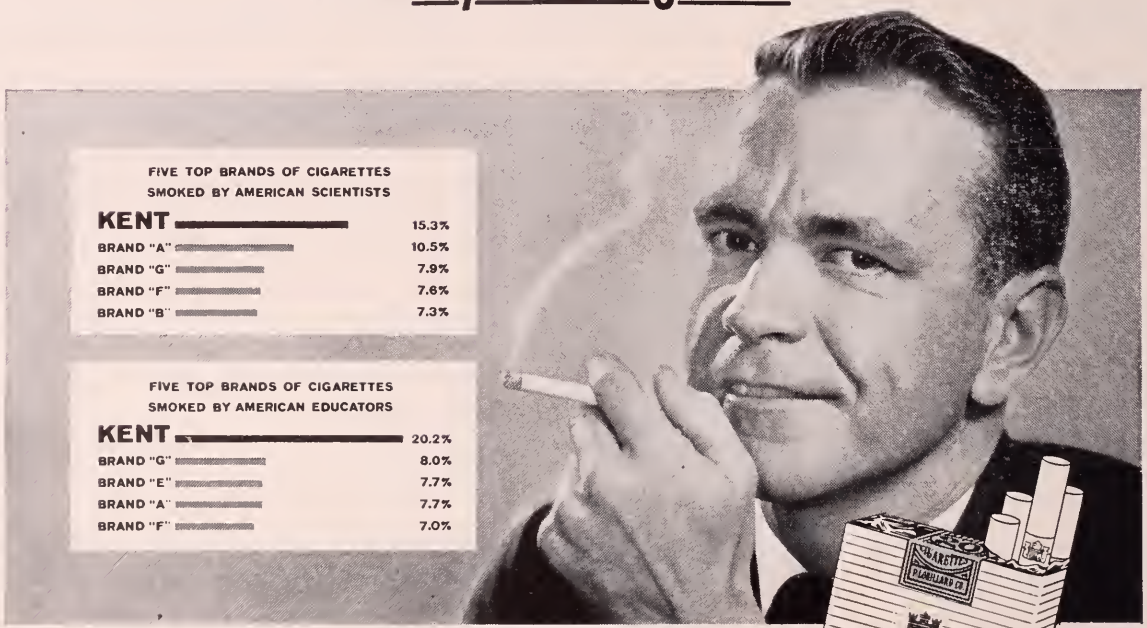
The pharmaceutical industry's investment in research has been growing much faster than the industry itself. Last year the prescription drug companies spent a record $197 million for research, a five-fold increase in the space of ten years. Such an investment is possible, of course, only when there are profits. • This growth in privately financed research has sent the volume of laboratory failures soaring. For two years in a row the pharmaceutical industry has tested more than 100,000 substances in the search for new medicines. Fewer than two per cent showed enough promise for clinical testing. Only a handful will ever be sold as prescription drugs. The odds against finding a product with therapeutic value probably exceeded 2000-to-1. • But year by year, as the failures mount, the successes also increase, putting new or improved medications at the disposal of the medical profession. And the public benefits through better health, specific cures, shorter hospitalization, longer lives. • This is only one part of the massive assault on disease that engages the health team headed by the medical profession and embracing hospitals, nurses, pharmacists, technicians, and colleges. It is an effort that could only take place in a society which encourages individual freedom and guarantees incentives to freedom of enterprise.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

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than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.



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If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

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upper respiratory infections

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capsules

The Original Tetracycline Phosphate Complex

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effective control of pathogens...with an unsurpassed record of safety and tolerance



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SUPPLY: TETREX Capsules — tetracycline phosphate complex — each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup -- tetracycline (ammonium polyphosphate buffered) syrup — equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

IN CONTRACEPTION...



WHY IS SPEEDIER SPERMICIDAL ACTION IMPORTANT?

Because a swift-acting spermicide best meets the variables of spermatozoan activity.

Lanesta Gel, "...found to immobilize human spermatozoa in one-third to one-eighth the time required by five of the leading contraceptive products currently available . . ."* thus provides the *extra* margin of assurance in conception control. The accelerated action of Lanesta Gel — it kills sperm in minutes instead of hours — may well mean the difference between success and failure.

**Berberian, D. A., and Slighter, R. G.: J.A.M.A.* 168:2257 *(Dec. 27) 1958.*

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. Spermicidal action is greatly accelerated by the addition of 10% NaCl in ionic form. Ricinoleic acid facilitates the rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



new Lanesta® Gel

Supplied: Lanesta Exquiset . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio Distributed by GEORGE A. BREON & CO., New York 18, N. Y.

A product of Lanteen® research.



the complaint: "nervous indigestion"

the diagnosis: any of several nonspecific and functional gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

the prescription: a new formulation incorporated in an enteric-coated tablet, providing the multiple actions of widely accepted Donnatal® and Entozyme.®

the dosage: two tablets three times a day, or as indicated.

in the gastric-soluble outer layer:

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (⅛ gr.)	8.1 mg.
Pepsin, N. F.	150 mg.

in the enteric-coated core:

Pancreatin, N. F.	300 mg.
Bile salts	150 mg.

antispasmodic • sedative • digestant

DONNAZYME®

A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA



more effective than salicylate alone in antirheumatic therapy

PABALATE®

Robins

COMBINING MUTUALLY SYNERGISTIC NON-STEROID ANTIRHEUMATICS

"superior to aspirin" — ". . . evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."[1]

In each yellow enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.)	0.3 Gm.
Sodium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

For the patient who should avoid sodium

PABALATE®-SODIUM FREE

Same formula as Pabalate, with sodium salts replaced by potassium salts (pink)

For the patient who requires steroids

PABALATE®-HC

Pabalate with Hydrocortisone

In each light blue enteric-coated PABALATE-HC tablet:

Hydrocortisone	2.5 mg.
Potassium salicylate (5 gr.)	0.3 Gm.
Potassium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

A. H. ROBINS CO., INC., Richmond 20, Virginia









IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride
NASAL SOLUTIONS AND SPRAYS

VOLUME XLVII
NUMBER 5



NICOZOL®

ORIGINAL FORMULA

The ideal cerebral tonic and stimulant for the aged.

NICOZOL therapy (the original formula) affords prompt relief of apathy. Patients generally look better, feel better; become more cooperative, cheerful and easier to manage.
No dangerous side effects.

NICOZOL contains pentylenetetrazol and nicotinic acid

For relief of agitation and hostility: NICOZOL with reserpine Tablets

Supply: Capsules • Elixir

REFER TO PDR see page 669

DRUG Specialties INC.

Write for professional sample and literature.

WINSTON-SALEM 1, NORTH CAROLINA

DEDICATED TO SERVING THE SOUTHERN PHYSICIAN



A variety of diet dishes to choose from. Ham 'n' egg rolls, eggplant casserole, garden beans, oyster stew, gelatin and—beer!

The secret of a successful low-purine diet is acceptance

The acceptance of any diet depends on its appetite appeal. And this low-purine diet is unusually appetizing! Ham rolls stuffed with scrambled eggs or chilled egg salad make a delicious entree, as does a casserole of eggplant and tomato layered alternately with cottage cheese.

A dash of lemon juice flavors fresh vegetables like string beans and beets. Fresh skim milk mixed with dry skim milk powder add a "creamy" taste to oyster stew. Tuna-burgers go nicely with noodles. Fruits and gelatins make excellent, easy desserts, while corn and rice flakes brighten breakfasts.



With your approval, a glass of beer can add zest to your patient's diet.

104 calories,
17 mg. Sodium/8 oz. glass
(Average of American Beers)

United States Brewers Foundation

If you'd like reprints of this and 11 other different diet menus for your patients, write United States Brewers Foundation, 535 Fifth Avenue, N.Y. 17, N.Y.



CONFIDENCE

and well placed too!

The ophthalmologist knows that when he recommends a GUILD OPTICIAN, the service and quality which are a Guild tradition help to make his patient satisfied. He has confidence that his GUILD OPTICIAN will get the job done right.

GUILD Rx OPTICIANS

Guild of Prescription Opticians of Florida

Sun. Mon. Tue. Wed. Thur. Fri. Sat.

Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

[redacted]

in premenstrual tension

only neo Bromth

treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

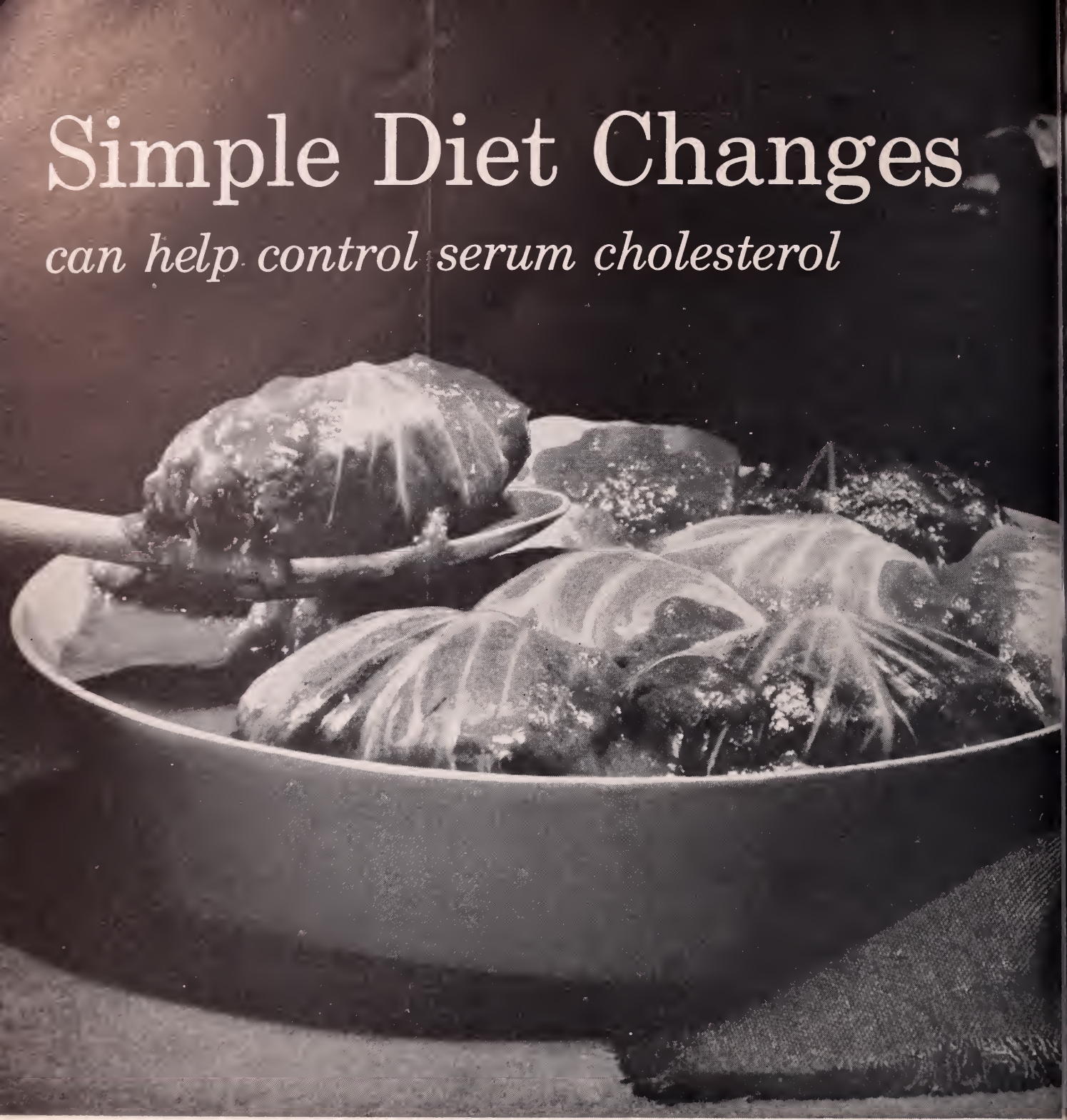
neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee

Simple Diet Changes

can help control serum cholesterol



Fortunately for the patient's morale — often all that is necessary when you want to prescribe a regimen to reduce serum cholesterol is to...

1. control the amount of calories and the type of dietary fat... and
2. make a simple modification in the method of food preparation, using poly-unsaturated vegetable oil in place of saturated fats

Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

After adjusting total fat and calorie intake, the sim ple replacement of *saturated* fats (those used at th table and in cooking) with *poly*-unsaturated Wesso makes possible a most subtle dietary change, ye conforms completely to therapeutic requirements

Uniformity you can depend on. Wesson has poly-unsaturated content better than 50%. Only th lightest cottonseed oils of high iodine numbe are selected for Wesson and no significant varia tions in standards are permitted in the 22 exactin specifications required before bottling.

Wesson satisfies the most exacting appetites To be effective, a diet must be *eaten* by the patient



The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . . winterized and of selected quality	
Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

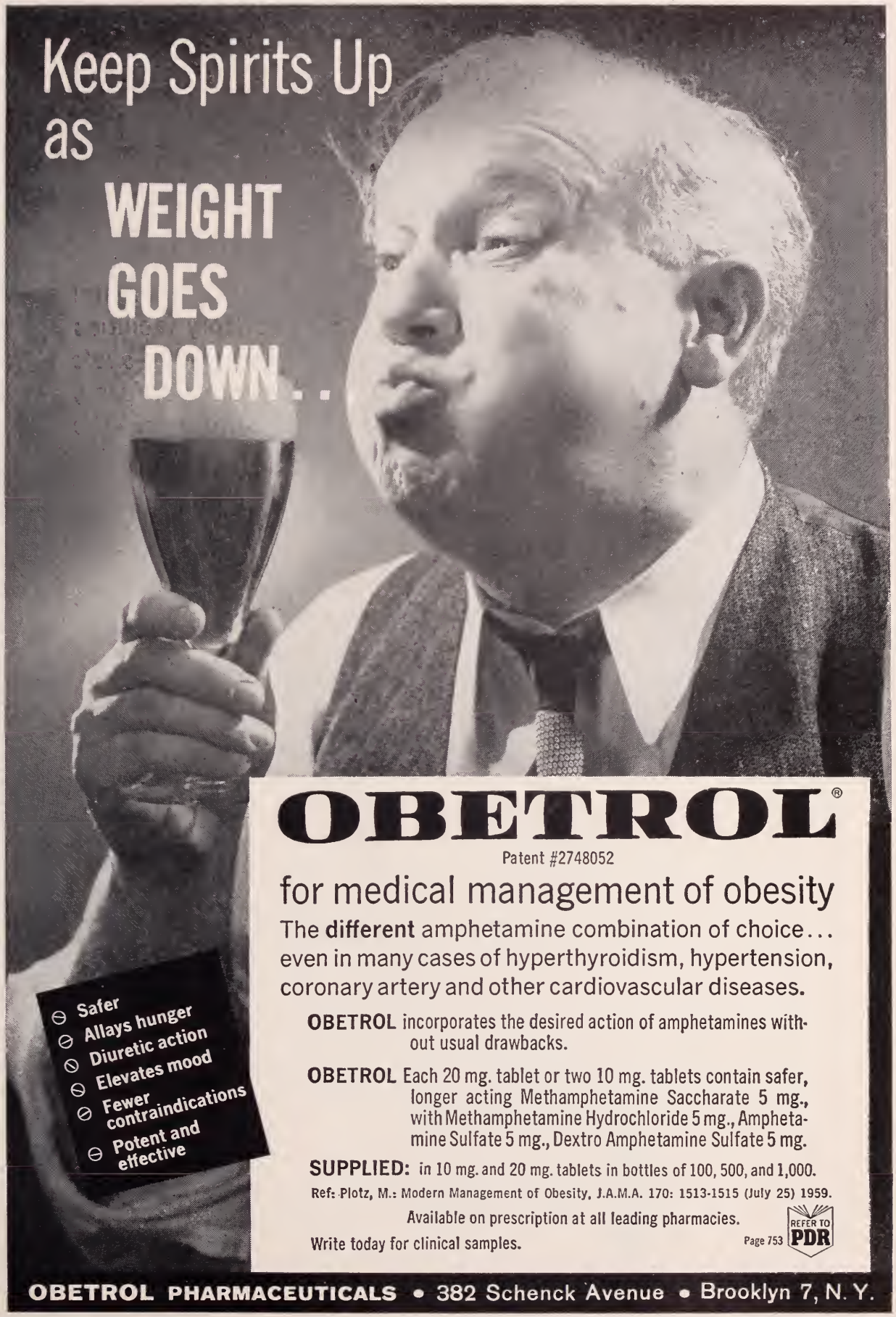
An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

©Florida Citrus Commission, Lakeland, Florida


Keep Spirits Up
as
WEIGHT
GOES
DOWN . .
⊖ Safer
⊖ Allays hunger
⊖ Diuretic action
⊖ Elevates mood
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OBETROL®
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for medical management of obesity
The different amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.
OBETROL incorporates the desired action of amphetamines without usual drawbacks.
OBETROL Each 20 mg. tablet or two 10 mg. tablets contain safer, longer acting Methamphetamine Saccharate 5 mg., with Methamphetamine Hydrochloride 5 mg., Amphetamine Sulfate 5 mg., Dextro Amphetamine Sulfate 5 mg.
SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.
Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.
Available on prescription at all leading pharmacies.
Write today for clinical samples.
Page 753
REFER TO PDR
OBETROL PHARMACEUTICALS • 382 Schenck Avenue • Brooklyn 7, N. Y.

basic in the care of the aging

℞ Metalex®





when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*



when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*



when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

contain
the
bacteria-prone
cold

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)



inner
protection
with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · Lincoln, Nebraska
a division of The Wander Company

BIRTHS AND DEATHS

Births

Dr. and Mrs. Thomas S. Edwards of Jacksonville announce the birth of a daughter, Virginia Gwaltney, on September 19, 1960.

Dr. and Mrs. George R. Gage of Coral Gables announce the birth of a son, Richard Francis, on July 7, 1960.

Deaths — Members

Beaumont, Godfrey L., Sebring.....September 19, 1960
Greene, Ralph J., Perry.....August 3, 1960
Manning, William S., Jacksonville.....August 22, 1960
Montgomery, Kenneth E.,
West Palm Beach.....September 19, 1960
Thomas, Abraham F., Cocoa.....September 7, 1960

Deaths — Other Doctors

Nebinger, Reid, St. Petersburg.....June 12, 1960
Patterson, James P., Jacksonville.....June 5, 1960
Pierce, Robert S., Marianna.....February 2, 1960
Sheiber, Leo, Vero Beach.....June 2, 1960

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Arroyo, Pedro Jr., Miami
Kirby, Taylor H. Jr., Gainesville
Lambert, Walter R., North Miami
Schultz, Everett H. Jr., Gainesville
Williamson, Harold L., Tampa

Associate

Acton, Rush K., Miami
Burgh, Lois C., Orlando
Cheslock, William B., Orlando
Cremer, Leonard E., No. Miami Beach
Felsenstein, Morton, Miami
Flitman, Donald B., So. Miami
Freier, Eugene H., Orlando
Gillman, Arthur, Miami
Hall, Marshall F., Miami
Jernigan, James A., Winter Park
Jones, Jenner G., Orlando
Kantor, Norman, Miami
Mitchel, Stanley D., No. Miami Beach
Mitchell, William C., Winter Park
Parsons, Robert L., Orlando
Pike, Robert E., Miami
Raymond, Harry P. Jr., Orlando
Rosenberg, Donald G., No. Miami Beach
Rosenstein, Ira N., Miami
Rountree, Mary E., Miami
Silverblatt, Charles W., Coral Gables
Silverman, Leonard M., Miami Beach

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Hospital, Physicians and Laboratory Supplies & Equipment

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Telephone FR 6-8286

depth

in topical anesthesia

New 4% Xylocaine® HCl applied topically to the larynx, pharynx, and trachea, gives fast, intense and profound anesthesia for endoscopic procedures. Whenever effective anesthesia of the mucosa of the eye, ear, nose and throat is required, topical Xylocaine HCl 4% offers all these advantages ▪ fast anesthetic action ▪ intense depth of anesthesia—not just surface analgesia ▪ effectiveness in small volumes—average 4 cc. ▪ patients experience no pain ▪ relatively nonirritating and nonsensitizing ▪ side effects are extremely rare. In ophthalmology, Xylocaine HCl 4% used both topically and by retrobulbar injection, provides fast, deep, and enduring anesthesia for a wide variety of major as well as minor surgical techniques. Xylocaine® HCl (brand of lidocaine*)

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OBITUARIES

Edward F. Aarons Jr.

Dr. Edward F. Aarons Jr. of Pensacola died in that city on May 30, 1960. He was 67 years of age.

A native Floridian, Dr. Aarons was born in Pensacola on Oct. 24, 1892. He attended the public schools of Pensacola and received his premedical training at Knoxville College in Knoxville, Tenn. To pursue his medical education he then entered Meharry Medical College in Nashville, Tenn., and was graduated in medicine there on May 3, 1917.

In 1920, Dr. Aarons located in Pensacola and continued to practice medicine there for 40 years. He was a member of the attending staff of Escambia General, Sacred Heart and Baptist hospitals. He served as Medical Director of Our Lady of Angels Maternity Hospital from the time it began operation in March 1946 until his death.

Dr. Aarons was a member of the Escambia County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association, the National Medical Association and the Gulf Coast Medical Society and was affiliated with the John A. Andrew Clinical Society at Tuskegee Institute, Alabama, and the Florida A. & M. College Clinical Society. He was a member of the African Methodist Episcopal Church.

Sanford C. Colley

Dr. Sanford C. Colley of Mount Dora, a practicing physician in Tavares for 45 years, died in Tavares on June 29, 1960. He was 71 years of

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tinnitus
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relieved in
circulatory disturbances
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In patients with disturbances of the inner ear— impaired hearing, tinnitus or vertigo — Arlidin produced remission of their chief complaint in over 50% of cases. Rubin and Anderson state "we were very much encouraged, inasmuch as no other vasodilator that we have used has ever achieved more than a 25 percent response."

"significant hearing improvement"

was obtained in 32 of the 75 patients studied.

rationale:

The clinicians note that impairment in hearing, disturbance in balance, and tinnitus involving the inner ear "may be explained on the basis of labyrinthine artery insufficiency" due to spasm or obstruction of the vessels. Arlidin was found to be "superior to all other vasodilating measures" in increasing blood flow through these vessels and in allaying spasm.

age. Services were held in Mount Dora with interment in the Tavares Cemetery.

A native of Elmore County, Alabama, Dr. Colley was born there on April 9, 1889. He received his medical education in Atlanta, Ga., at the Southern College of Medicine and Surgery, later Emory University, and was awarded the degree of Doctor of Medicine by that institution in 1914.

In 1915 he was licensed to practice in Florida and located in Tavares. Except for a period spent in military service in World War I, he continued to engage in the general practice of medicine and surgery there through the years. Locally, he was a member of the Methodist Church, the Masonic Lodge, the Shrine, the Kiwanis Club and the American Legion. He was a member of the board of directors of the Lake Region Packing Association of Tavares, the Bank of Tavares and Waterman Memorial Hospital of Eustis. He built the Mount Dora Clinic.

A past president and also a former secretary of the Lake County Medical Society, Dr. Colley recently became a life member of the Florida Medical Association. He also held membership in the American Medical Association.

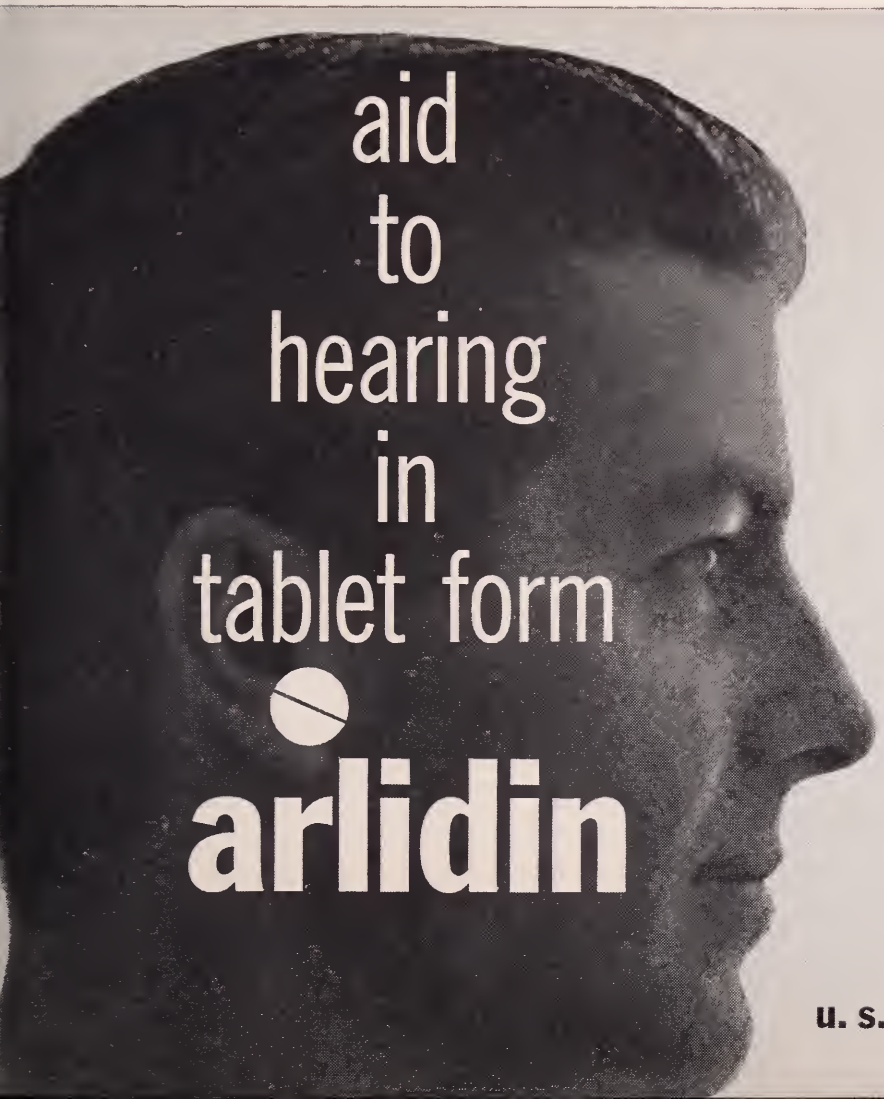
Surviving are the widow, Mrs. Nellie T. Colley, of Mount Dora; a son, S. Carey Colley, of Tavares; a daughter, Mrs. James B. Glanton, of Orlando; three brothers, A. B. Colley, of Prattsville, Ala., George Colley, of Birmingham, Ala., and Miles Colley, of Elmore, Ala.; two sisters, Mrs. Pearl Jordan, of Montgomery, Ala., and Mrs. T. E. McNeal, of Trussville, Ala.; and six grandchildren.

Lester Ivin Berk

Dr. Lester Ivin Berk of Miami Beach died in that city on May 20, 1960. He was 44 years of age. Interment took place in Red Bank, N. J.

Born in New York City on Nov. 17, 1915, Dr. Berk was reared in Red Bank and received his early schooling there. For his premedical education he attended Gettysburg College in Gettysburg, Pa., and was graduated cum laude in June 1937. He studied medicine at the University of Pittsburgh School of Medicine and was awarded

(Continued on page 617)



...“superior to all other vasodilating measures in its effect on the labyrinthine arteries.”

...efficacious where other vasodilators failed



Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution. See PDR for dosage and packaging.

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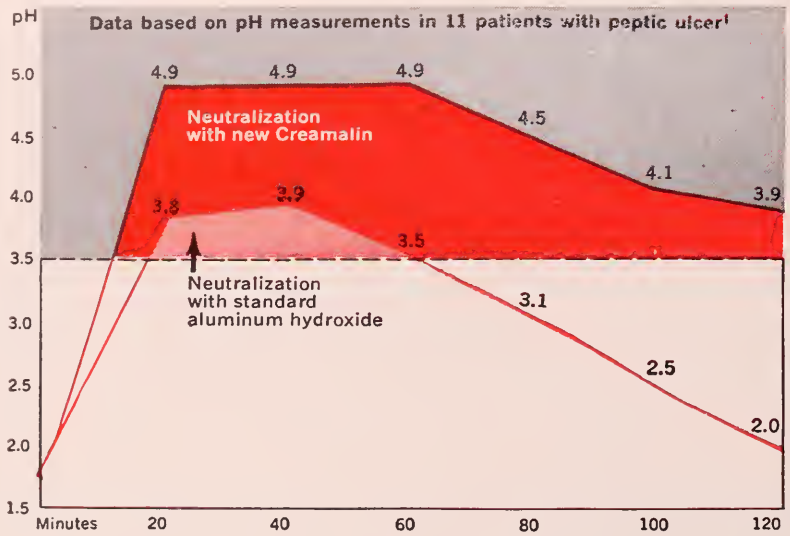
1. Rubin, W., and Anderson, J. R.: Angiology 9:256, 1958.

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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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on the pathogenesis of pyelonephritis:

"An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 5000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

The "exquisite sensitivity"[2] of the medulla to infection (as compared with the cortex), highlights the importance of obstruction to the urine flow in the pathogenesis of pyelonephritis. "There is good cause to support the belief that many, perhaps most, cases of human pyelonephritis are the result of infection which reaches the kidney from the lower urinary tract."[3]

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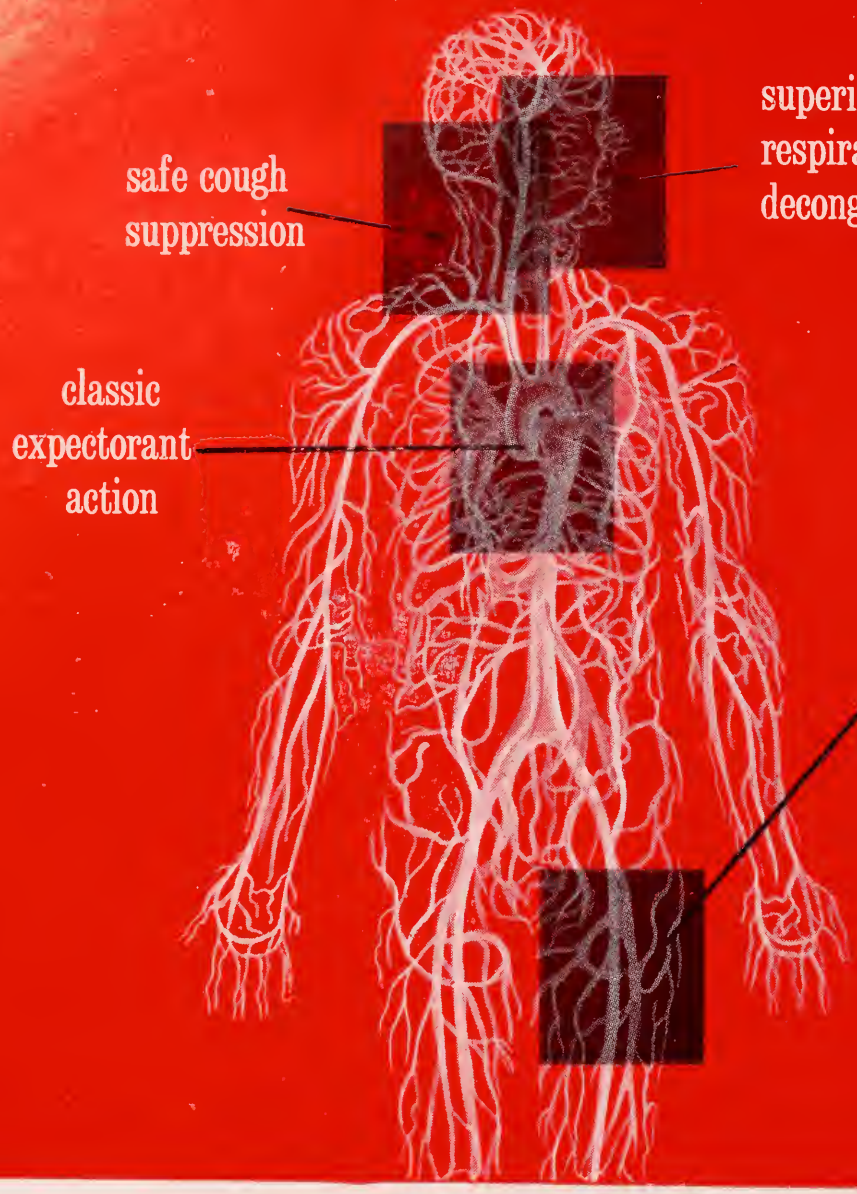
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References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

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Dosage: *Adults and children over 12* — one tablet in the morning, midafternoon and at bedtime. Each tablet should be swallowed whole to preserve the timed-release action.

Each tsp. (5 ml.) of Tussagesic Suspension provides:

TRIAMINIC®	25 mg.
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TERPIN HYDRATE	90 mg.
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Tussagesic Suspension is especially suited for children and for adults who prefer liquid medication; it is pleasantly flavored, non-narcotic and non-alcoholic.

Dosage (to be taken every 3 or 4 hours): *Adults and children over 12* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

*TRADEMARK

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(Continued from page 613)

the degree of Doctor of Medicine by that institution in 1943. After serving an internship at the Pittsburgh Medical Center from 1943 to 1944, he entered the United States Army in October 1944 and was discharged in December 1946.

While in service Dr. Berk was Assistant Chief of the Medical Services of the Public Health Headquarters in Seoul, Korea. He established the first maternity center in Korea and reorganized all clinics, dispensaries and hospitals in the American occupied area of Korea formerly controlled by the Japanese. In Chung Chong, Korea, he served as Director of Public Health and Welfare and coordinated military and civilian programs of preventive medicine in the field of Public Health. One of his chief problems during the Korean conflict was the prevention of cholera epidemics. He was advisor to and supervisor of civil authorities on all public health matters including the distribution of physicians, nurses, dentists, veterinarians and other personnel for the United States Public Health. He received a letter of commendation for duties performed and was awarded the Asiatic-Pacific campaign medal.

In 1948, Dr. Berk located in Miami Beach and engaged in the general practice of medicine there until he met his untimely death. He was a member of the staff of the Mount Sinai Hospital. Locally he was affiliated with the Elks Lodge and Temple Israel.

A member of the Dade County Medical Association, Dr. Berk also held membership in the Florida Medical Association. In addition, he was a member of the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Florence Berk; a daughter, Elizabeth Ann, and a son, William Stewart, all of Miami Beach. His mother, a brother and a sister also survive.

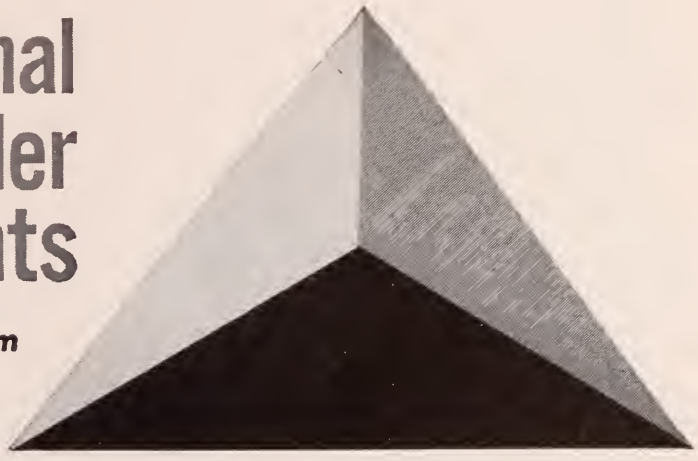
George Shepard Berg

Dr. George Shepard Berg of Miami died at a local hospital on June 13, 1960, following an illness of several months with Hodgkin's disease. He was 36 years of age.

Born in 1924, Dr. Berg received his academic education at Cornell University. For his medical training he attended New York University College of Medicine, where he was awarded membership in Phi Beta Kappa and AOA honorary societies and received the degree of Doctor of

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Medicine. An internship followed at Mount Sinai Hospital and pediatric residencies at Bellevue and New York hospitals in New York City. He then practiced in Asbury Park, N. J., prior to serving in the Medical Corps of the United States Army from 1953 to 1955. After discharge from military service, he completed one year of specialization in pediatric allergy.

In August 1956, Dr. Berg began the practice of his specialty in Miami. He organized and was chief of the allergy clinic at Variety Children's Hospital and assistant chief of the Pediatric Allergy Clinic at Jackson Memorial Hospital. Also, he was an instructor at the University of Miami School of Medicine. Locally, he was active in community affairs, serving on the American Jewish Committee and the board of Jewish Family Service. He was a member of Temple Israel.

Dr. Berg held membership in the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a member of the American Association of Pediatricians and was doubly certified by the American Board of Pediatrics and Pediatric Allergy.

Surviving are the widow, Mrs. Helene Berg; a son, Peter, and two daughters, Susan and Elizabeth; and the parents, Mr. and Mrs. Joseph Berg, all of Miami.

BOOK REVIEWS

Metabolic Care of the Surgical Patient. By Francis D. Moore, M.D. Pp. 1011. Illus. 143. Price, $20.00. Philadelphia, W. B. Saunders Company, 1959.

This splendid text is truly a major contribution to the medical literature. It is monumental in effectively discussing the common bedside problems of surgical metabolic processes as well as the complicating surgical patterns that are so perplexing to this specialty. Dr. Francis D. Moore, the outstanding author, has carefully interrelated the surgical technique with surgical judgment, achieving a pleasant balance to save human lives. This very complex subject material is simplified by separating it into six sections:

1. The *Normal Patient and the Metabolism of Recovery,* in explicit terminology, includes the body composition, its metabolism and endocrinology at rest. From this basic point of view the author carries one into the realms of the various phases of metabolic response to injury and disease. He not only indulges in the young, but also the aged and the surgical risk patient.
2. The *Blood Volume* section meticulously endeavors to explain this subject in health as well as in the patient suffering with acute hemorrhage associated with and without the shock phenomenon. The author does not cease at this point, but continues to explain the effects and hazards of blood transfusions.

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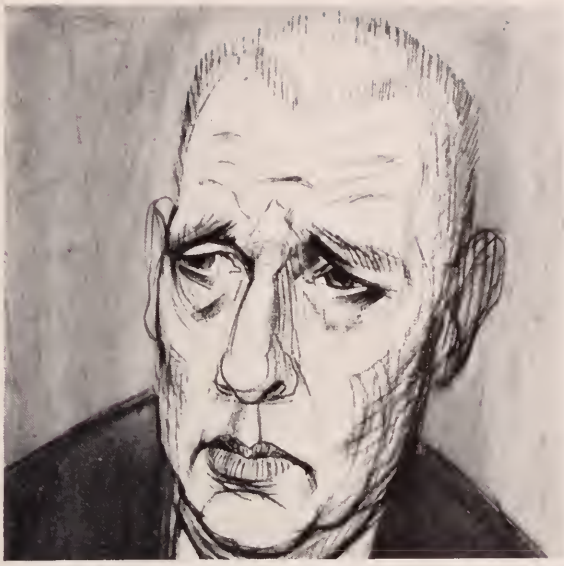
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3. The *Body Fluids and Electrolyte* portion of the book is dedicated to general views and disorders of hydration and dehydration, including the various changes that present problems to the surgeon in caring for balance of water, salt, acid and base in the body tissues.
4. *Calories and Nutrition* are studied from a starvation state which is beautifully exemplified by numerous working diagrams and charts. Dr. Moore modestly defines and discusses starvation by the phrase "loss of body substance." He divides this into five basic types seen in surgery: resting semi-starvation, resting total starvation, early and late post-traumatic catabolic weight loss and septic starvation. Everyone will enjoy perusing this section.
5. *Visceral Diseases* many times must be entertained when disorders of metabolism occur. These changes may involve any system or part thereof including the gastrointestinal tract, liver, pancreas, kidney, heart, lung, or endocrine glands. The various acute and chronic disturbances are listed and then treated individually. There are also a few important paragraphs devoted to extracorporeal circulation including the mechanics of the pump oxygenator.
6. *Fractures, Wounds and Burns* are discussed in the last section of this comprehensive review, and the author had in mind the various specialties that are so closely allied to surgery. The metabolic aspects of the multiple injury case are superbly challenged and conquered. The burn problem, which has probably been responsible for the surgeon's return to the basic sciences and academic medicine after so many years, is adeptly presented in a general plan characterized by four phases of initial catabolism, then the turning point, the period of spontaneous nitrogen anabolism and lastly the period of fat redeposition. Data are also furnished on atomic injuries.

The patterns of metabolic response in the normal and diseased are clarified by many graphs, charts and legends, each explicitly illustrated. The entire volume is supplemented with notes from the literature, case histories and comments. The appendix consists of surgical diets and parenteral supplements, and the bibliography contains nearly a thousand references to the literature. This book is a milestone in surgical biology, and the author should be commended on his method of presenting the confused subject material in such a pattern of simplicity. It must be extremely gratifying to the author to offer such a contribution to the world of surgical men.

Clifford C. Snyder, M.D.

Cancer of the Cervix. *Diagnosis of Early Forms.* Ciba Foundation Study Group No. 3. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 114. Illus. 27. Price, $2.50. Boston, Little, Brown and Company, 1959.

This booklet contains the papers presented in a study group on the diagnosis of early forms of cancer of the cervix, held at The Ciba Foundation in London in May 1959 with an international group of gynecologists participating.

Christopher's Minor Surgery. Edited by Alton Ochsner, M.D., F.A.C.S., and Michael E. DeBakey, M.D., F.A.C.S. Ed. 8. Pp. 539. Illus. 347 figures. Price, $10.50. Philadelphia, W. B. Saunders Company, 1959.

The current revision of this standard textbook has been done under the editorship of two eminent Southern surgeons. The majority of the chapters are written by

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staff members of the Tulane University School of Medicine with a scattering of representatives from other Southern schools. The over-all size of the book has been reduced somewhat from former editions. The present two column format is easy to read. The illustrations, both photographs and line drawings, are well reproduced and are pertinent although some chapters have many more than others. The chapter on anesthesia and resuscitation is an excellent one. Another chapter is directed to the surgical resident. The book in general is pointed at housestaff members and general practitioners. References are appended to most chapters; most have three to seven titles though some run to several pages, which seems unnecessarily complete for a book of this character. In general, the book serves its purpose well and is recommended.

G. T. H.

The Story of Dissection. By Jack Kevorkian, M.D. Pp. 80. Price $3.75. New York, Philosophical Library, 1959.

The author is a graduate of the University of Michigan Medical School at Ann Arbor. In this brief text he has outlined the historical reports on dissection from the times of antiquity through periods of dominance of Greek, Roman and Byzantine medicine; through the middle ages and Renaissance to the twentieth century. There are 16 illustrations in the book, all portraits of physicians whose names are closely related to the history of dissection. There is also a graph on the last page outlining the appearance of dissection in history and showing the increased incidence which occurred in the three to four hundred years prior to the Christian era and the rather marked rise that started taking place with the twelfth century A.D.

The book is well printed in clear type that is easy to read.

W. D. S.

Schifferes' Family Medical Encyclopedia. By Justus J. Schifferes, Ph.D. Pp. 620. Price, $0.50. New York, Permabooks, 1959.

This Health Education Council book provides easily understood, common sense information whose mastery will render medical and life emergencies less likely to happen. In addition, it aims to create attitudes toward health, disease, and specific disease conditions which will lead toward healthier living generally and permit a person to overcome the obstacles of disease. The psychological as well as the physical aspects of health are considered. Approximately 2,500 medical topics of general interest and importance are described, which, taken together, provide a brief but comprehensive summary of modern medical knowledge, at the level at which the average person is interested. Here are three books in one—an authoritative medical dictionary, an indispensable first-aid manual and a comprehensive medical encyclopedia, fully illustrated, to serve as a guide to health and medical care for the entire family. The author, who is Director of the Health Education Council, was assisted in the preparation of this ready reference by a Medical Advisory Board of eight physicians.

Laboratory Tests in Common Use. By Solomon Garb, M.D. Ed. 2. Pp. 185. Price, $2.50. New York, Springer Publishing Company, Inc., 1959.

This book was written primarily for the nurse, the graduate as well as the student, but with the hope that it would prove useful to the laboratory technician, medical secretary, and medical student and become a convenient source of practical information for the physician. The aspects with which the nurse is most directly concerned are fully described for each test, while other information is summarized. The purpose of each test is given in sufficient detail to enable the reader to under-

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stand why the test was ordered and what the results may signify. The procedure for collecting the specimen is described in such a manner that the nurse can collect and send to the laboratory the correct specimen; laboratory procedures are briefly stated in general terms. This second edition has been brought up to date by the addition of 10 laboratory tests, several tables, and other material. A chapter has been added on "Normal Values in Infants and Children."

A Cookbook For Diabetics. *Recipes From the ADA Forecast.* By Deaconess Maude Behrman. Pp. 174. Price, $1.00. New York, The American Diabetes Association, Inc., 1959.

Sister Behrman has been teaching home economics and devising low sugar food recipes for diabetic patients for many years. This book contains a selection of her best work as published in the ADA Forecast, monthly journal for diabetic patients. While the recipes do fit the old-fashioned concepts of the pre-insulin era of diabetology which were and still are supported by most of the leaders in the American Diabetes Association, they look a little silly to those in the rank and file who have awakened to the fact that the most unnecessary thing in the management of diabetic patients is the rigid restriction in sugar intake advocated in this book.

At this time when many diabetologists have for years discarded the food tables and food scales, with the result of better and more faithful patient cooperation and better diabetic control, with a great reduction in the so-called "typical diabetic complications," this cookbook gives an impression of being passé, almost Victorian. Still, for those who must yet adhere to the rigidity of diabetological concepts which some Northern clinics find hard to give up, this book will be of help in keeping their patients under some illusory discipline. This reviewer cannot avoid the feeling that it will be the last of its kind.

C. P. L.

Christopher's Textbook of Surgery. Edited by Loyal Davis, M.D. Ed. 7. Pp. 1551. Illus. 1597 on 810 figs. Price $17.00. Philadelphia, W. B. Saunders Company, 1960.

In this seventh edition, 82 eminent contributors have produced a thorough revision of this famous work. Each contributor, in setting forth the surgical fruits gained from his clinical insight, experience and skill, surveys a wide enough area to build a logical and useful discussion—resulting in a work of exceptional integration and simplicity. Every common surgical disease is considered, with its etiology, pathology, clinical course, diagnosis, treatment, preoperative and postoperative care, complications and prognosis. Completely rewritten sections by new authors cover infections, the abdominal wall and peritoneum, surgery of peptic ulcer, diseases and tumors of the lungs and bronchi, urinary system, male reproductive system, the foot, amputations and artificial limbs. New material has been added on such topics as stapes mobilization, use of fluothane and chlorprocaine, evaluation of sympathectomy for peripheral vascular disease, Zollinger-Ellison syndrome, lymphangiography, open methods of heart repair, management of bleeding esophageal varices, and pros and cons of splenorenal and portacaval shunts. There are expanded discussions on the physiology of wound healing, methods of bandaging, trauma in auto accidents, current status of simple mastectomy, and sympathectomy for hypertension.

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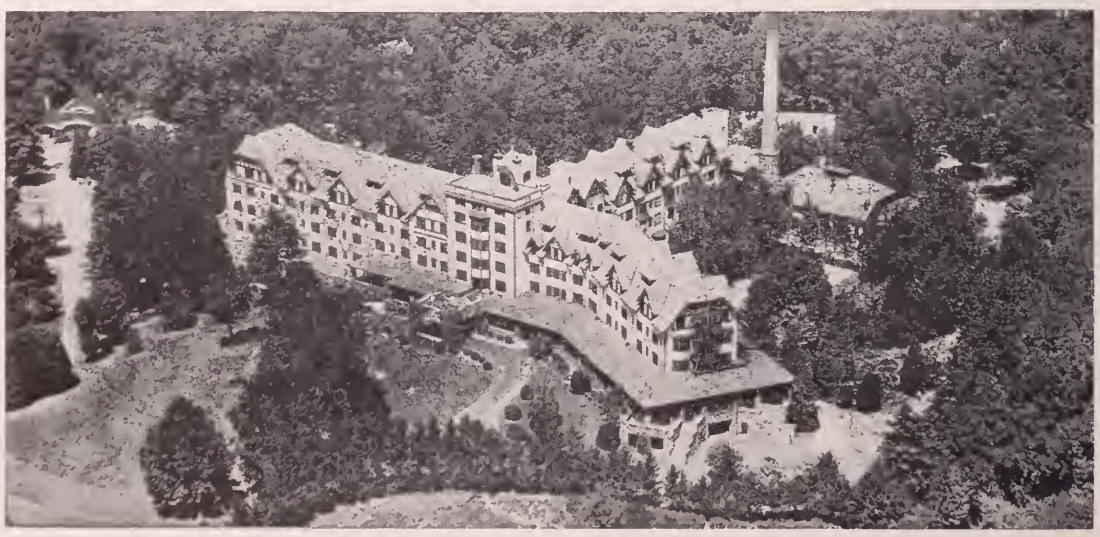
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Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
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Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	42	267
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	124	1035
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	357
Clay	Marcus B. Bergh, Orange Park	John M. Malone, Green Cove Springs			10
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	12
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	261
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st. Wed.	4	34
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Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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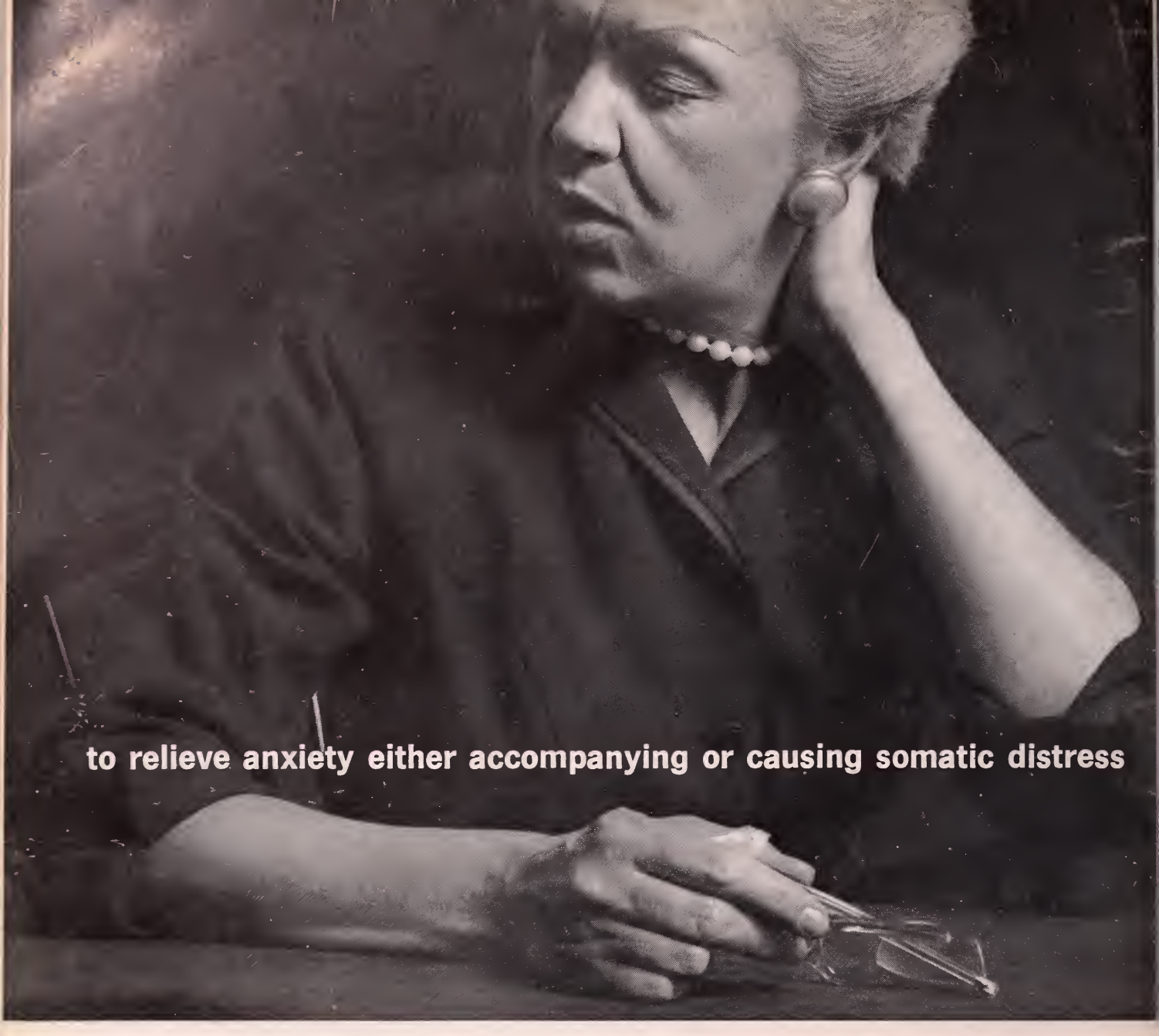
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

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December, 1960
Vol. XLVII - No. 6

THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

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The Last Word . . .

Impact of the Presidential Election on the Medical Profession

EDWARD R. ANNIS, M.D.
MIAMI

Among the major factors leading to the election of Senator John F. Kennedy was the preponderance of labor votes, labor money, and labor effort in the key industrial states whose electoral votes made the decision. Certain labor leaders have been working for a number of years to gain control of the government, and it became very apparent during the Democratic National Convention that labor was determined this year to elect a labor candidate to carry out their objectives. In view of the fact that Walter Reuther, head of the United Automobile Workers, top man in the AFL-CIO and COPE, has repeatedly stated that it is no secret that labor is looking to the day when every man, woman and child in America has medical care made available to them by the government, financed by the Social Security system, physicians would do well to look at the record and plan for the future from a realistic point of view.

The COPE organization in its report to the Congress admitted expenditures during the 1960 campaign of $728,000. This merely reports the amount of money spent on the national campaign and says nothing about the extraordinary sums raised and used in individual states to defeat so-called "conservatives" and elect more men pledged to labor.

The political action fund for Dave MacDonald's United Steel Workers reported contributing $13,500 to committees for Kennedy and $97,000 in behalf of 107 Democratic Congressional candidates. Many have attributed Kennedy's success in winning New York's electoral votes almost directly to the efforts of David Dubinsky, Ladies Garment Union President, who in addition to block-by-block work in New York, set up a series of national broadcasts over 250 radio stations, eight in all, costing $10,000 each. As concluded in the Washington News Letter, "Human Events," "aside from the tremendous financial help from unions to Kennedy and liberal candidates already down in the books, there is no way to ascertain the amount Reuther and other union bosses have expended in building their vast machine of salaried campaign workers and paid propagandists in labor's big drive for the White House."

Now that they have elected a President, the union bosses will undoubtedly try to force through a labor-socialist program. This would be cause for greater alarm if the victory had been of landslide proportions rather than a nip-and-tuck battle down to the final wire. The supporters of the Republican nominee, many millions of whom had to come from the Democratic ranks, should serve as a brake on unbridled labor legislation. All who are interested in preserving the soundness of the dollar and slowing down our march toward Socialism would do well to increase their efforts to support the coalition of conservative Southern Democrats and Northern Republicans who will still control the balance of power and, by seniority, the major committees in both the House and the Senate.

It would appear that our immediate problem is an increasing effort to make good medical care available to all of our citizens and at the same time to let the people of America know what we are doing. Here in Florida we have had a hospitalization for the indigent program successfully operating for over five years and yet few of our citizens know anything about it and most of our doctors are not fully cognizant of what is being and what can be accomplished. The medical bill passed by the last session of the Congress is a good bill and will assure medical care for any one of our senior citizens who is in need. There is no federal limitation on medical service provided under the bill, but implementation of the program in Florida demands enabling legislation through our legislature. To the degree that we do a good job in Florida, we can depend upon the continued support of our Congressional representatives in the Congress to block any legislation to further socialize the practice of medicine.

Your Florida Medical Association is working diligently to this end and will continue to accumulate all factual data which will be helpful to our legislators when they meet to establish a participating plan for Florida. It will then be our job, as physicians of Florida, to show the Congress and the people that the job can be done without jeopardizing our economy or our American free enterprise system.

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References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

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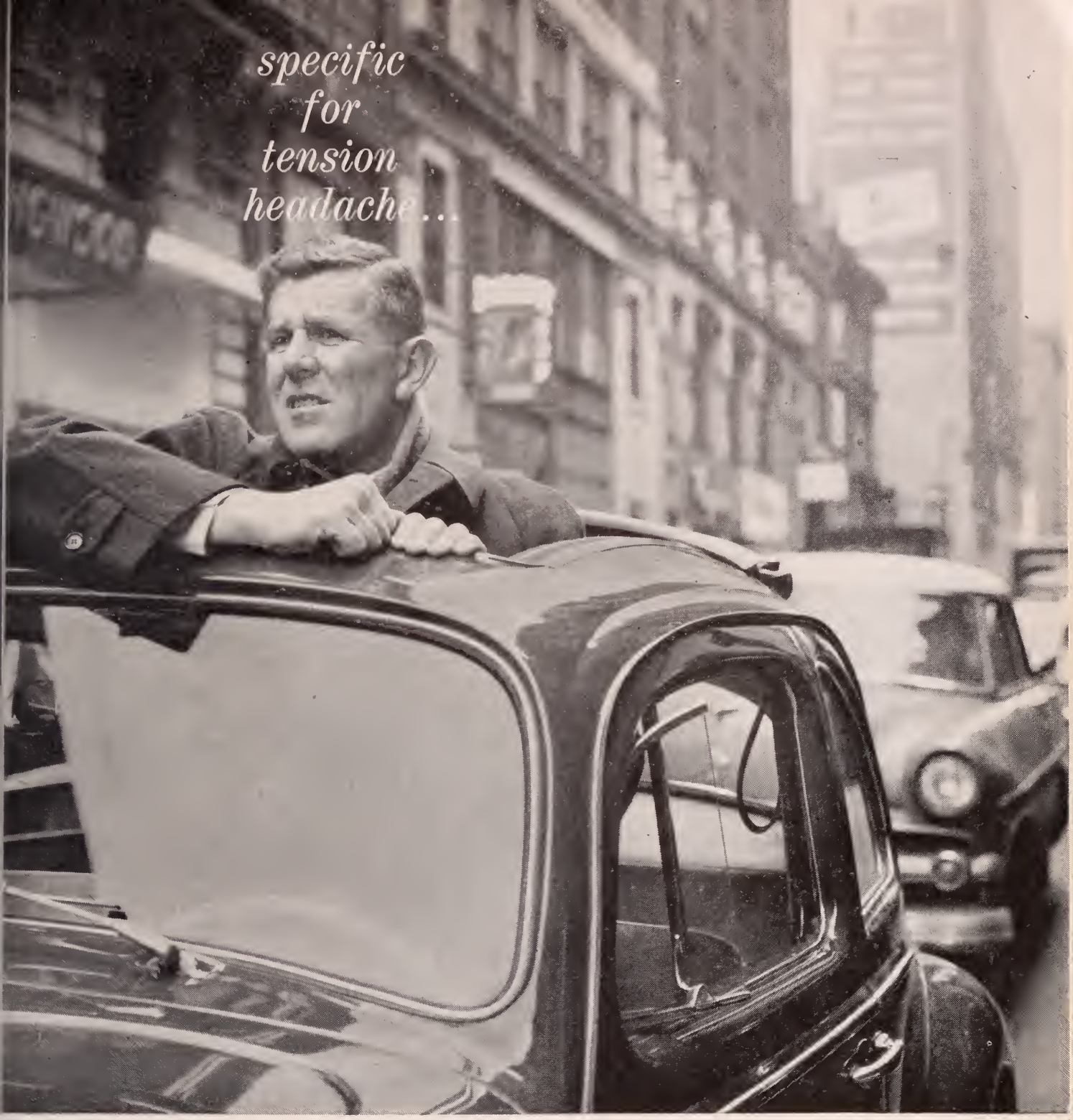


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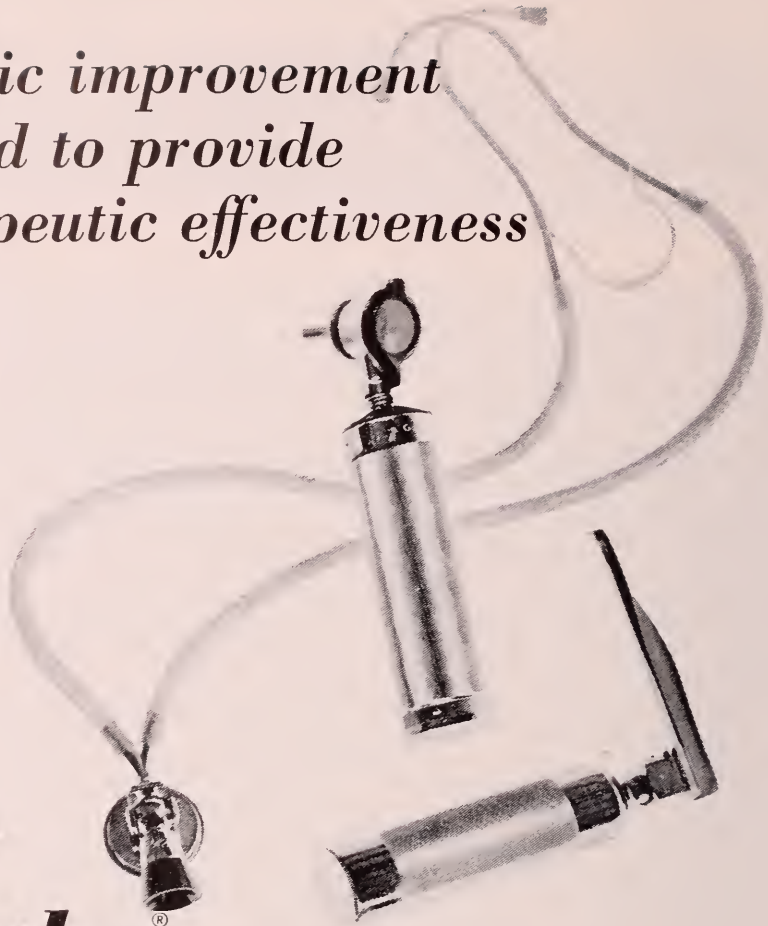
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1. Stephens, V. C., *et al.:* J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.:* Antibiotics Annual, p. 893, 1959-1960.
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4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

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Volume XLVII, No. 6, December, 1960

Griseofulvin in the Treatment of Fungus Infections

J. GRAHAM SMITH JR., M.D., HARVEY BLANK, M.D.,
A. ROBERT GODDARD, M.D., AND NARDO ZAIAS, M.D.
MIAMI

Griseofulvin was first isolated over 20 years ago from Penicillium griseofulvum.[18] It has also been obtained from other species of Penicillium;[5] however, its chemical structure has no resemblance to penicillin.[11]

Its effectiveness in experimental ringworm infections in guinea pigs was first reported by Gentles[8] in mid-August 1958. This report stimulated the initial use of griseofulvin in the United States in mid-September 1958 by Blank and Smith[3] at Jackson Memorial Hospital for a patient with an unusually severe granulomatous infection with Trichophyton rubrum. Following the improvement of this patient, a preliminary study of the effectiveness of oral griseofulvin was undertaken and the results reported at the American Academy of Dermatology and Syphilology in December 1958.[2] Early clinical studies on griseofulvin were also initiated during 1958 in Vienna[23] and London.[29] Subsequent work has amply confirmed the beneficial effects of oral griseofulvin in the treatment of dermatophytosis.[4,10,24,27,30]

Within four hours after oral administration, griseofulvin blood levels reach a peak with traces remaining in the blood for 72 to 96 hours.[1,6,28] The drug is deposited in the keratin of skin, hair, and nails[9,25] and prevents growth of fungi through its protective fungistatic shield.[26] As the drug-laden keratin is pushed distally, proximal invasion of fungi is inhibited. The keratin containing fungi is gradually sloughed off in the skin or cut off as in nails or hair.

Treatment of Superficial Fungus Infections

Griseofulvin is effective only in the treatment of the dermatophytosis caused by the species of three genera of fungi: Microsporum, Trichophyton, and Epidermophyton.[26] The drug does not influence bacterial or fungus infections such as candidiasis, erythrasma, tinea versicolor, or the subcutaneous and systemic fungus diseases.[4,7] It is not particularly effective when used topically.[20]

This narrow spectrum of activity means that precise diagnosis is essential. Scrapings of scales, the tops of blisters, fluorescent or broken-off hairs, particles of friable or discolored nails, or other material from suspect lesions must be examined for hyphae microscopically in 15 per cent potassium hydroxide and cultures of these materials must be planted on Sabouraud's or other suitable culture medium for an exact etiologic diagnosis.

After the diagnosis is established, griseofulvin administration may be begun. The usual dosage for adults is 1 Gm. daily. Children should receive 15 mg. of griseofulvin per pound daily. It

From the Department of Dermatology, University of Miami School of Medicine, Miami.

Dr. Smith is a Special Post-Doctoral Fellow of the National Institute of Arthritis and Metabolic Disease.

Dr. Smith's present address: Division of Dermatology, Department of Medicine, Duke University Medical Center, Durham, N. C.

This study was supported in part by grants from the National Institutes of Health, P.H.S. No. E-1546 and in part by U.S. Army Contract No. DA-49-007-MD-731.

The griseofulvin used in this study was supplied as Grifulvin by McNeil Laboratories, Inc., Philadelphia.

Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 9, 1960.



Fig. 1.—a. Extensive T. rubrum infection of the shoulder and arm. b. Result after 30 days' treatment with 1 Gm. griseofulvin daily.

is not known if this dosage is better divided over the day or given all at once. Smaller doses are not uniformly effective and sometimes doses larger than 1 Gm. daily may be necessary for clinical response. This larger dose may be required by some persons because of impaired gastrointestinal absorption since no resistant strains of dermatophytes have been isolated. Response to treatment depends on the rate of keratinization and the time necessary for desquamation of infected keratinized structures; therefore further details of therapy will be outlined by major site of involvement rather than by organism.

Scalp (tinea capitis)

Fluorescent (Microsporum audouini, M. canis)[12-14] and nonfluorescent (caused by various Trichophyton species) ringworm[21] respond to griseofulvin. X-ray epilation of the scalp is no longer necessary in the management of ringworm of the scalp and should be abandoned. A single oral dose of 3 Gm. of griseofulvin is usually effective in fluorescent ringworm.[4] The patient should be followed at monthly intervals for evidence of relapse, and areas of infected hair should be clipped at monthly intervals.

Nonfluorescent ringworm should be treated daily with griseofulvin: 1 Gm. for adults, 15 mg. per pound for children. Treatment should continue for four to six weeks until all evidence of infection is gone.

Skin (tinea corporis, tinea cruris)

The patient with extensive T. rubrum ringworm over the body, commonly seen in Florida as compared with more northern states, responds rapidly to griseofulvin (fig. 1a,b). Within 72 to 96 hours, itching is relieved. After two or three weeks, all lesions of the vellus skin have subsided leaving residual pigmentation occasionally. Often the patients also have infections of the palms, soles, or nails. In the absence of infections in these areas, treatment for two to four weeks usually is adequate. Sometimes more prolonged therapy is necessary and higher doses than 1 Gm. daily of griseofulvin may be required. Especially if nails, palms, or soles are involved, treatment must be prolonged.

Palms and Soles (tinea manuum, tinea pedis)

Acute athlete's foot with oozing, vesicles or bullae, crusting and purulent exudate is best treated with bland topical therapy. If T. rubrum is causing the infection, oral griseofulvin should be used along with topical therapy. The infections due to dermatophytes other than T. rubrum generally respond with topical therapy alone. Scaling or thickened hyperkeratotic T. rubrum infections of the palms and soles respond more quickly when griseofulvin is combined with a topical medication such as benzoic acid 6 per cent and salicylic acid 3 per cent in polyethylene glycol ointment (Whitfield's ointment USP XV).[22] Treatment should be extended for four to eight weeks. When nails are infected, treatment for even longer may be necessary.

Eczematous eruptions with superimposed dermatophytosis do not get well invariably with the elimination of the ringworm infection, and suitable topical therapy is indicated.

Nails (tinea unguium)

Fingernails take three to four months to grow out (fig. 2a,b) and toenails six to eight months



Fig. 2.—a. Onychomycosis due to T. rubrum. b. Result after four months' treatment with 1 Gm. of griseofulvin daily.

or longer. If, therefore, griseofulvin is used for nail infections, long term therapy will be necessary. Treatment of nails is indicated for cosmetic reasons, or if the nail infection seems to be the source of cutaneous reinfection. Nail infections are rarely symptomatic. Nails should be cut closely during treatment and therapy should be continued until all nails have grown out normally. More rapid growth of toenails and a decrease in duration of therapy may be achieved by avulsing affected toenails.[17] Even with doses of griseofulvin up to 3 Gm. daily, the individual toenails next to nails which are clearing may not respond. Nails on one foot may respond but not on the other.[30] The explanation for these phenomena is not clear and avulsion probably should be considered in such instances. Candidiasis or bacterial infections (often due to Pseudomonas aeruginosa) may coexist with nail infections due to Epidermophyton or Trichophyton species and must be treated simultaneously to obtain good results.

Side Effects and Toxicity

Griseofulvin seems to be a very safe drug.[2,3,27] Mild gastrointestinal distress, loose stools, and headaches occur, but usually subside with continued treatment. Urticarial and morbilliform drug eruptions are seen rarely. There is no cross-reactivity with penicillin, and persons sensitive to penicillin have not reacted to griseofulvin. Ill-defined dizziness with slowing of reaction time to coordinated movements has been observed rarely. These psychomotor disturbances have been noted only with higher doses of griseofulvin and have disappeared on daily doses of 1 Gm.

In animals, doses of griseofulvin in excess of 50 times that used in man have produced colchicine-like effects.[19] Evidence, however, of bone marrow depression has not been observed commonly, and routine blood counts are probably not necessary. Sperm counts and testicular biopsies of persons taking 2 Gm. of griseofulvin daily for six months have shown no abnormalities.[16] No detrimental effects on liver or renal function have been observed although there may be increases occasionally in the 24 hour urine protein excretion.[15]

Relapse

Because of the mildness of symptomatology and responsiveness of dermatologic infection to repeated courses of the drug, accurate figures as to incidence of relapse have been difficult to obtain. Relapses may occur when a nail reservoir has not been completely eliminated, but patients have been followed up to six months with mycologically proved involvement of the nails without cutaneous relapse. Occasional relapse of ringworm of the scalp has been observed. Still further follow-up of patients is necessary before the final answer to this problem will be available.

Summary

Superficial fungus infections caused by species of Microsporum, Trichophyton, and Epidermophyton respond to oral administration of griseofulvin. Because of its narrow spectrum of activ-

ity, accurate diagnosis is essential before treatment is begun.

The daily dose of griseofulvin should be 1 Gm. for adults and 15 mg. per pound for children. Larger doses may be required but usually not exceeding 3 Gm. daily. Lesions clear in about two to four weeks on the skin, four to eight weeks on the palms and soles, four to six weeks on the scalp, and four to eight months or longer on the nails. Toxic side effects are uncommon and usually not severe when they occur.

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Recent Advances in Diagnostic Cardiology

Philip Samet, M.D., William H.Bernstein, M.D.,
and Robert S. Litwak, M.D.
Miami Beach

Developments in surgical cardiac therapy in the past decade have focused attention on the necessity for more accurate anatomic diagnosis and more critical evaluation of the resulting physiologic abnormalties. The purpose of this paper is to outline some of these newer diagnostic approaches from both the clinical and laboratory viewpoints.

Correlation of cardiac catheterization and phonocardiographic data and findings on physical examination have defined the value of fixed (not varying with the phase of respiration) wide splitting of the second pulmonic sound in the diagnosis of atrial septal defect and partial anomalous pulmonary venous drainage.[1,2] Patients with rheumatic heart disease and mitral stenosis commonly exhibit three heart sounds at the apex and pulmonary area, an accentuated first sound and two sounds at the end of systole. These latter sounds were formerly interpreted as a split second sound.[1] Simultaneous left atrial and left ventricular pressure curves together with the phonocardiogram have clearly demonstrated that the third sound is not a split second sound but an opening snap of the mitral valve, occurring simultaneously with the fall in left ventricular pressure below left atrial pressure as the mitral leaflets open to permit flow from atrium to ventricle.[3] Recognition of semilunar valve ejection clicks, really opening snaps of the aortic or pulmonary valve, has aided in the clinical recognition of aortic and pulmonic stenosis.[1,2] Differentiation of the pansystolic murmur of ventricular septal defect and mitral insufficiency from the diamond-shaped murmur of pulmonic or aortic stenosis has proved feasible.[2]

Conversely, catheterization data have demonstrated the limited value of the loudness of the second aortic sound in the recognition of physiologically significant aortic stenosis.[4] It has also become apparent that typical murmurs of mitral and aortic stenosis do not, even in symptomatic patients, per se signify the existence of physiologically and surgically significant stenosis. These murmurs may be observed in the absence of clinically significant mitral valve diastolic and aortic valve systolic gradients at left heart catheterization. These are but a few examples of how physiologic studies have advanced the value of clinical auscultation. The findings of arterial hypertension in the upper extremities and absent femoral pulses, especially in young patients, suggest coarctation of the aorta to all physicians;[5] less widely recognized is the value of simultaneous palpation of the radial and femoral pulses. In the normal subject the pulse wave arrives at the femoral artery in a few hundredths of a second earlier than at the radial artery. In coarctation the onsets of the pulse wave are simultaneous in these two vessels, or the normal relationship is reversed.

Cardiac fluoroscopy and radiography have contributed to our diagnostic abilities. The increased pulmonary vascular markings and hilar dance in the patient with a large left to right shunt resulting in increased pulmonary blood flow, the large central pulmonary arteries noted in conjunction with normal or decreased peripheral pulmonary vascular markings in the subject with severe pulmonary hypertension such as in patent ductus arteriosus with reversal of the shunt or in primary pulmonary hypertension, the localization of intracardiac calcification to the mitral or aortic valve in patients with rheumatic mitral or aortic stenosis respectively, the determination of individual cardiac chamber enlargement, and the frequency of a right aortic arch (20 per cent incidence) in patients with the tetralogy of Fallot are some illustrations of the value of present roentgenographic techniques. The recent development of 5 to 11 inch fluoroscopic image amplifiers with motion picture recording of the image noted therein offers exciting prospects for the immediate future. The combination of image intensi-

From the Cardio-Pulmonary Laboratory and the Department of Medicine, Mount Sinai Hospital, Miami Beach, and the Section of Cardiology, Department of Medicine, and the Department of Surgery, University of Miami School of Medicine, Coral Gables.

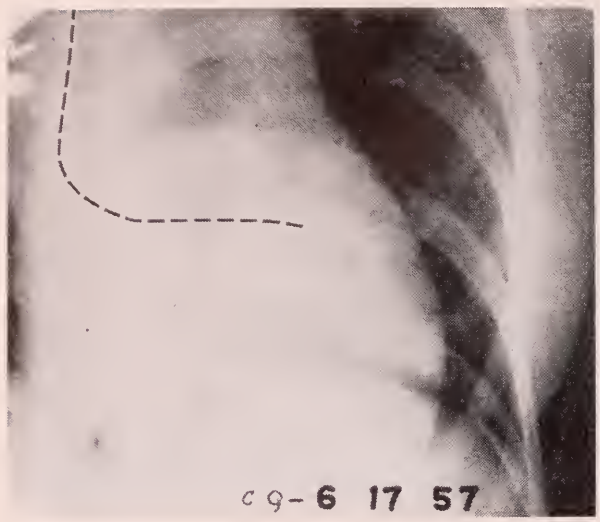


Fig. 1.—The catheter tip has been passed from the right atrium to the left atrium through an interatrial septal defect. Note the high level at which the tip passes across the midline structures.

fication and a 16 or 35 mm. motor-driven motion picture camera, cinefluorography, has permitted magnificent visualization of cardiac pathology and physiology when employed simultaneously with selective angiocardiography.[6] On the other hand roentgenkymography and electrokymography have contributed relatively little to modern cardiological practice.

Electrocardiography and vectorcardiography have shared in and contributed to diagnostic advances. The contributions of vectorcardiography have been most helpful in the differentiation of right ventricular hypertrophy and right bundle branch block. Failure to evolve a common lead system has hampered the development of vectorcardiography. Cabrera's concept of systolic and diastolic overloading of the right and left ventricle has evoked much comment. As recently noted by Cabrera and Gaxiola,[7] unjustified criticism and unjustified approval have often been afforded these interesting concepts. As originally published, systolic overloading of the right ventricle was characterized by a tall "R wave in the right precordial leads." Diastolic overloading of the right ventricle resulted in an incomplete right bundle branch block pattern. Systolic left ventricular overloading produced "flattening or negativity of the T wave as well as depression of the S-T segment in those leads where left ventricular potentials are transmitted." Diastolic overloading of the left ventricle was considered "to produce an elevation of both the R and T waves in those leads where the left ventricular potentials are transmitted." These concepts are of considerable interest in comprehension of the electrical pathogenesis of the pat-

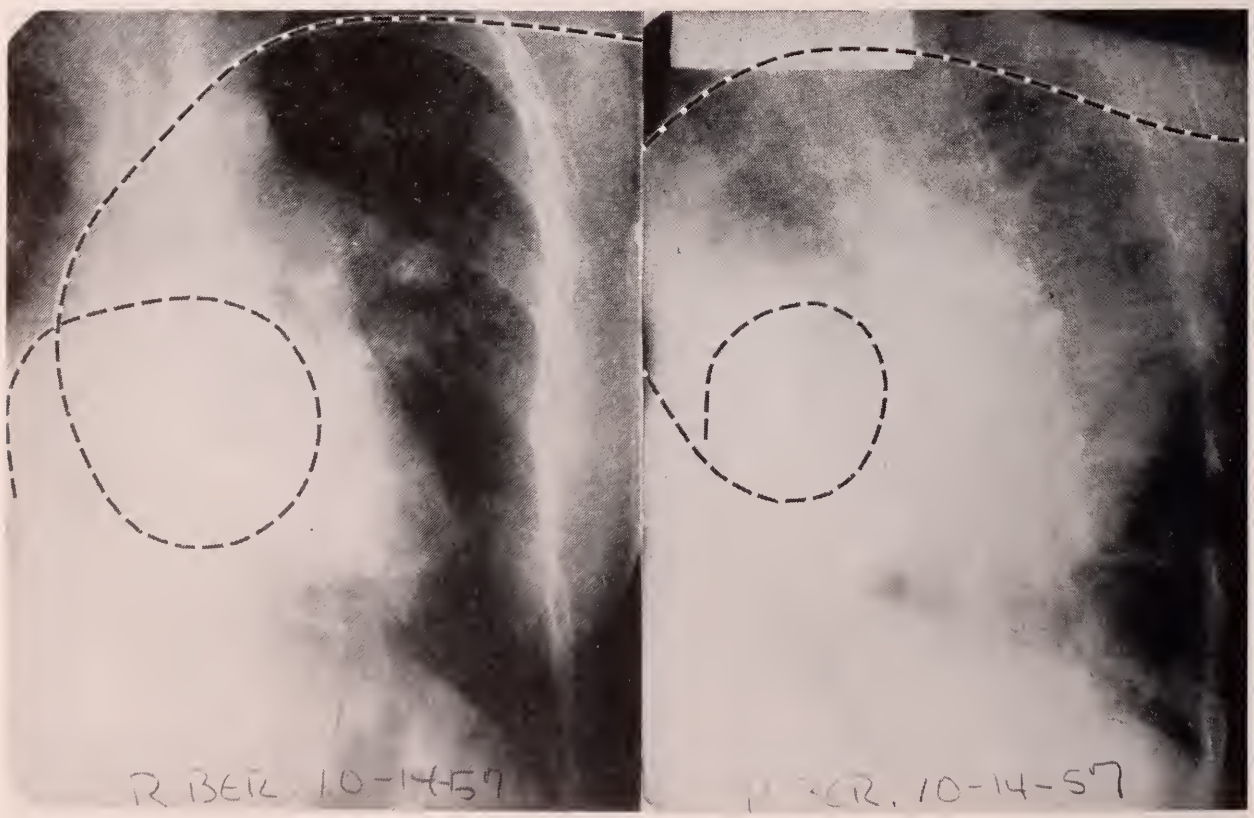


Fig. 2.—a. The catheter tip has passed from the right atrium to the left atrium and thence back to the right atrium; posteroanterior view. b. Left anterior oblique view of the same catheter position as in a. The posterior position of the catheter is to be noted.

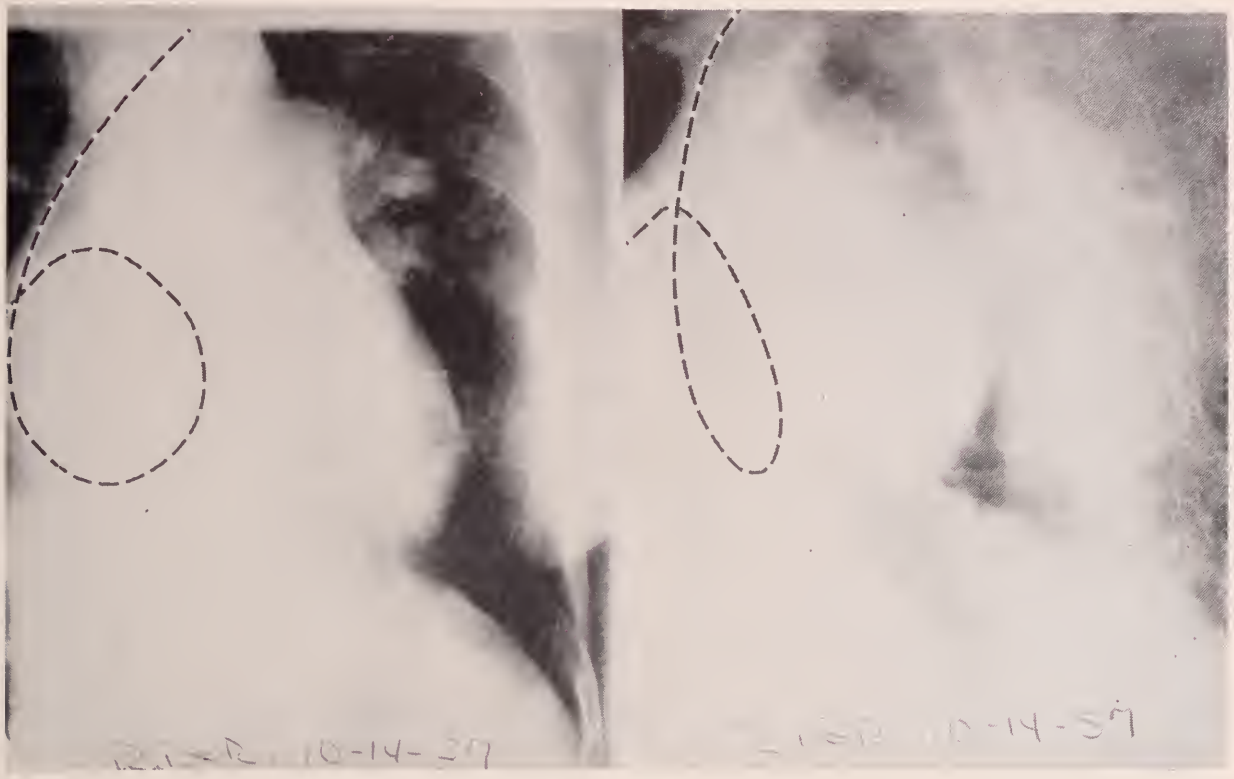


Fig. 3.—a. The catheter tip has been deliberately coiled in the large right atrium; posteroanterior view. b. Left anterior oblique view of the same catheter position as in a. The anterior position of the coiled catheter is readily noted.

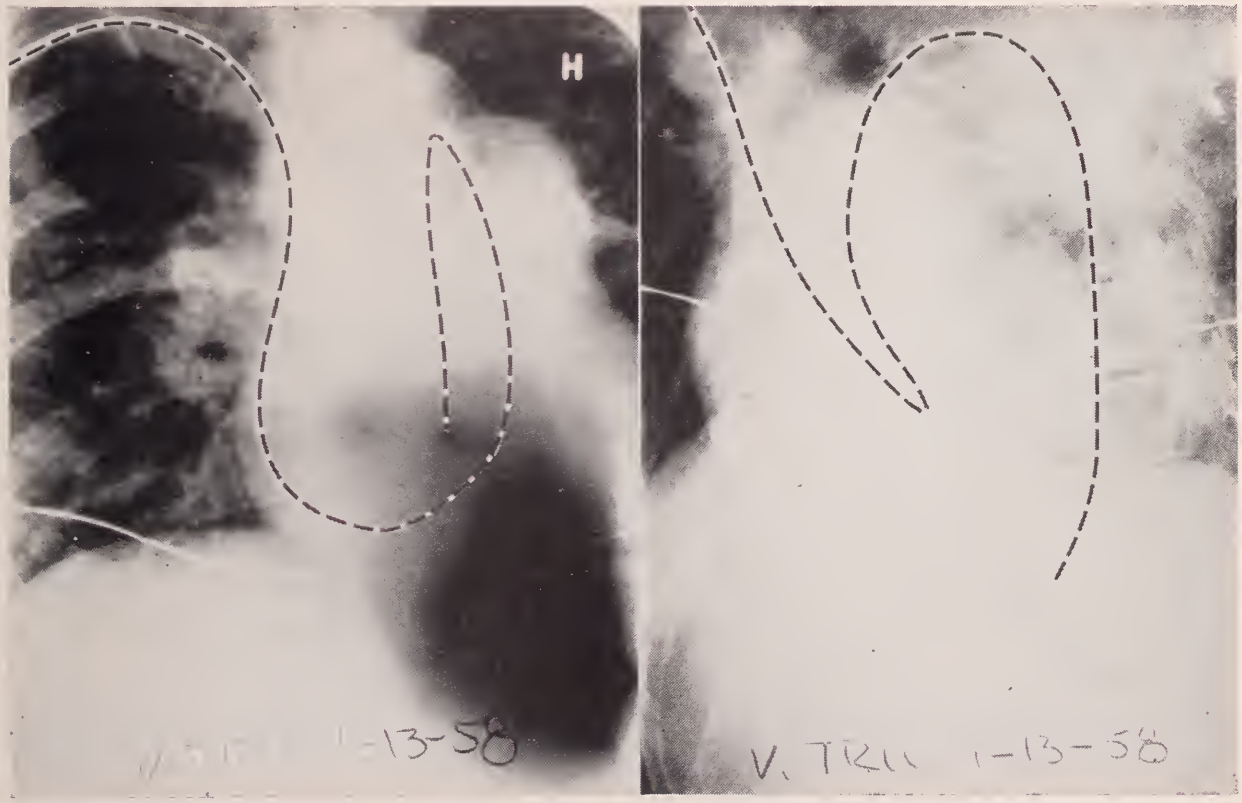


Fig. 4.—The catheter tip has passed from the pulmonary artery through a patent ductus arteriosus to the descending aorta; posteroanterior and left oblique anterior views.

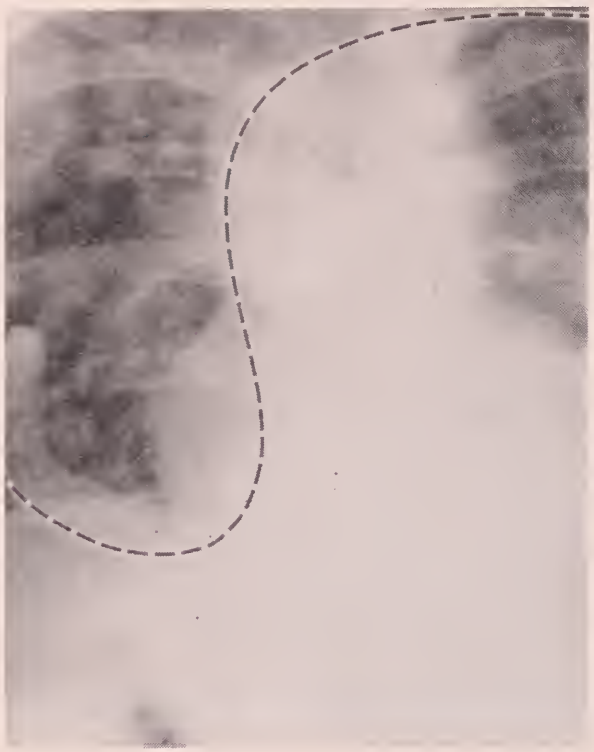


Fig. 5.—The catheter tip has passed from the right atrium to the inferior vena cava into an anomalously draining pulmonary vein. The course of the latter vein has been outlined with radiopaque contrast material.

terns noted in clinical electrocardiography despite the individual case variability encountered clinically. Cabrera has discussed the limitations in his concepts of systolic and diastolic overloading.[7]

Cardiac Catheterization

The major contributions to diagnostic cardiology in the past two decades have resulted from cardiac catheterization and angiocardiography. The techniques employed in both procedures continue to multiply. Most right heart catheterization is performed via an antecubital or saphenous vein cutdown. The right atrial posterior percutaneous puncture technique of Fisher is not commonly employed. Left heart catheterization is performed in a variety of ways including the direct left ventricular puncture of Brock, the transthoracic left atrial puncture technique of Fisher, transbronchial left atrial puncture, suprasternal notch left atrial puncture approach of Radner, retrograde left ventricular catheterization, and the newly developed transseptal left atrial puncture technique of Ross. The latter approach[8] to the left atrium (via passage of a long 17 gauge needle from the saphenous vein to the right atrium with direct puncture of the atrial septum to reach the left atrium) appears to be the procedure of choice at this time.

What information does right heart catheterization provide? The presence of abnormal anatomic pathways can be indisputably established by passage of the catheter tip from the right to the left heart. Figure 1 illustrates passage of the catheter tip from the right atrium to the left atrium in a patient with an interatrial septal defect. In figure

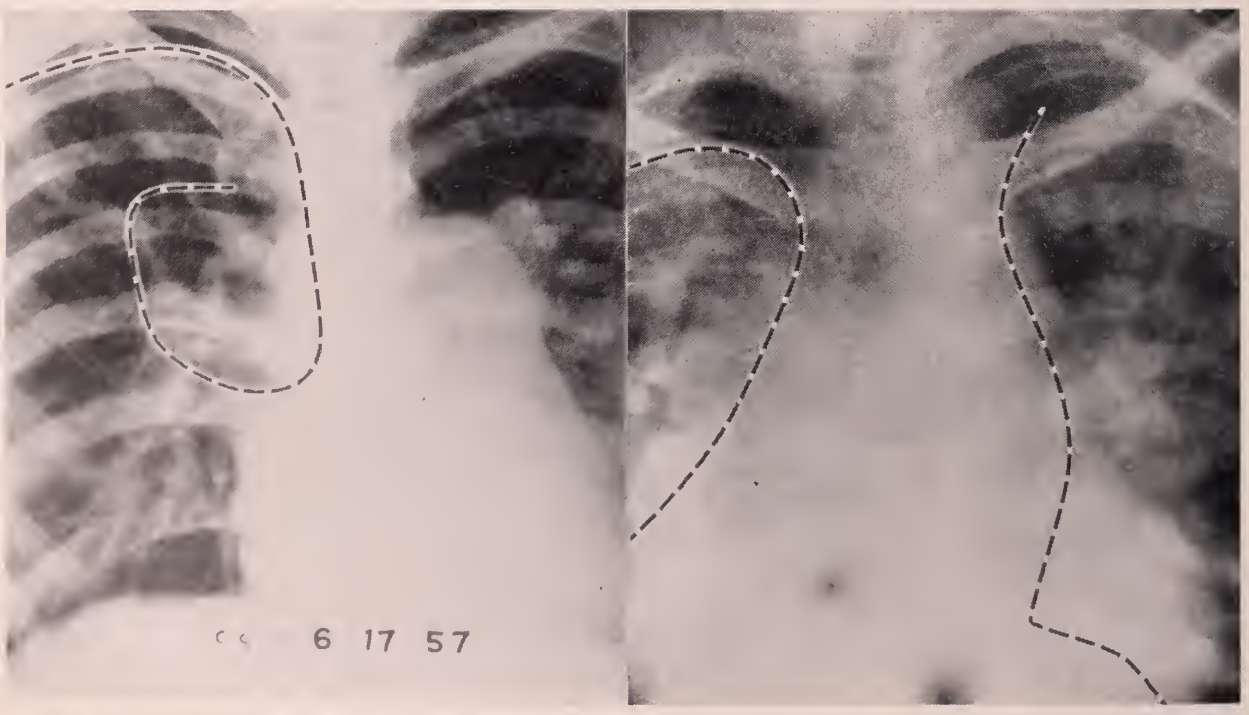


Fig. 6.—a. The catheter tip has passed from the right atrium to the right upper lung via an anomalously draining pulmonary vein. b. The catheter tip has passed down a right superior vena cava to the right atrium, a coronary sinus and into a left superior vena cava.

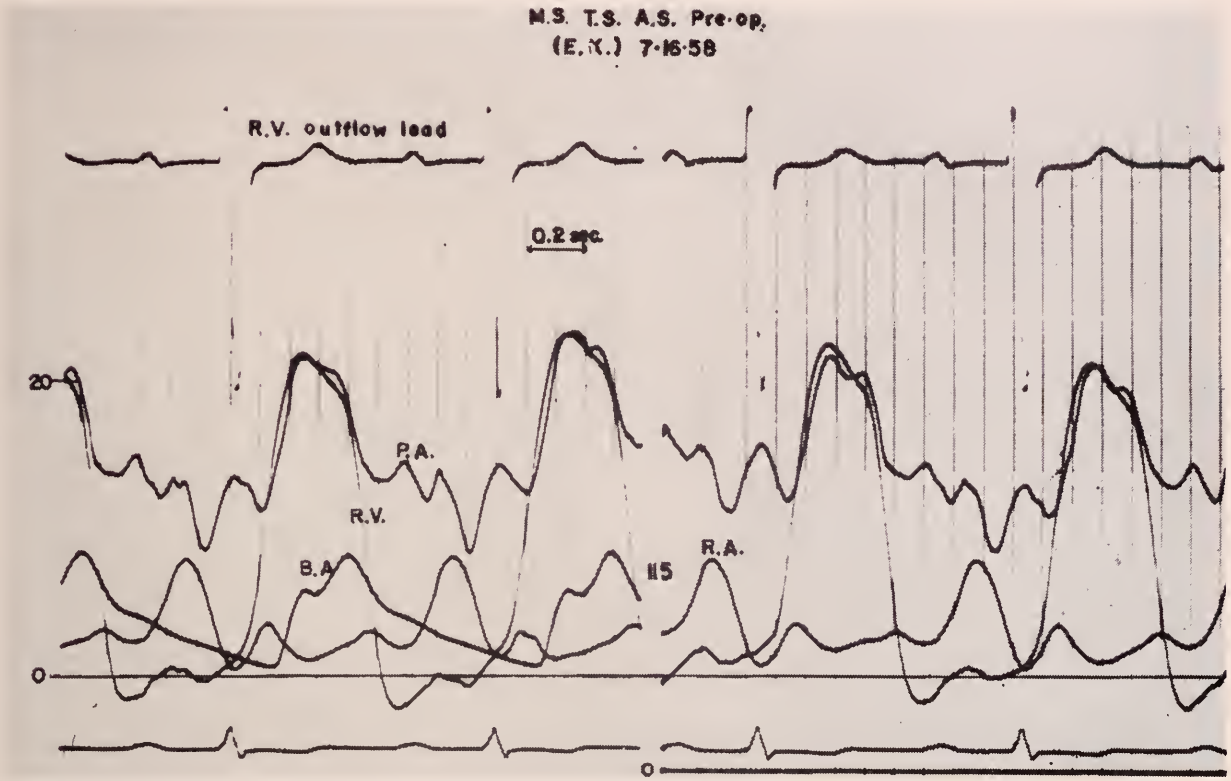


Fig. 7.—Tricuspid stenosis. The right atrial pressure is greater than the right ventricular pressure in diastole.

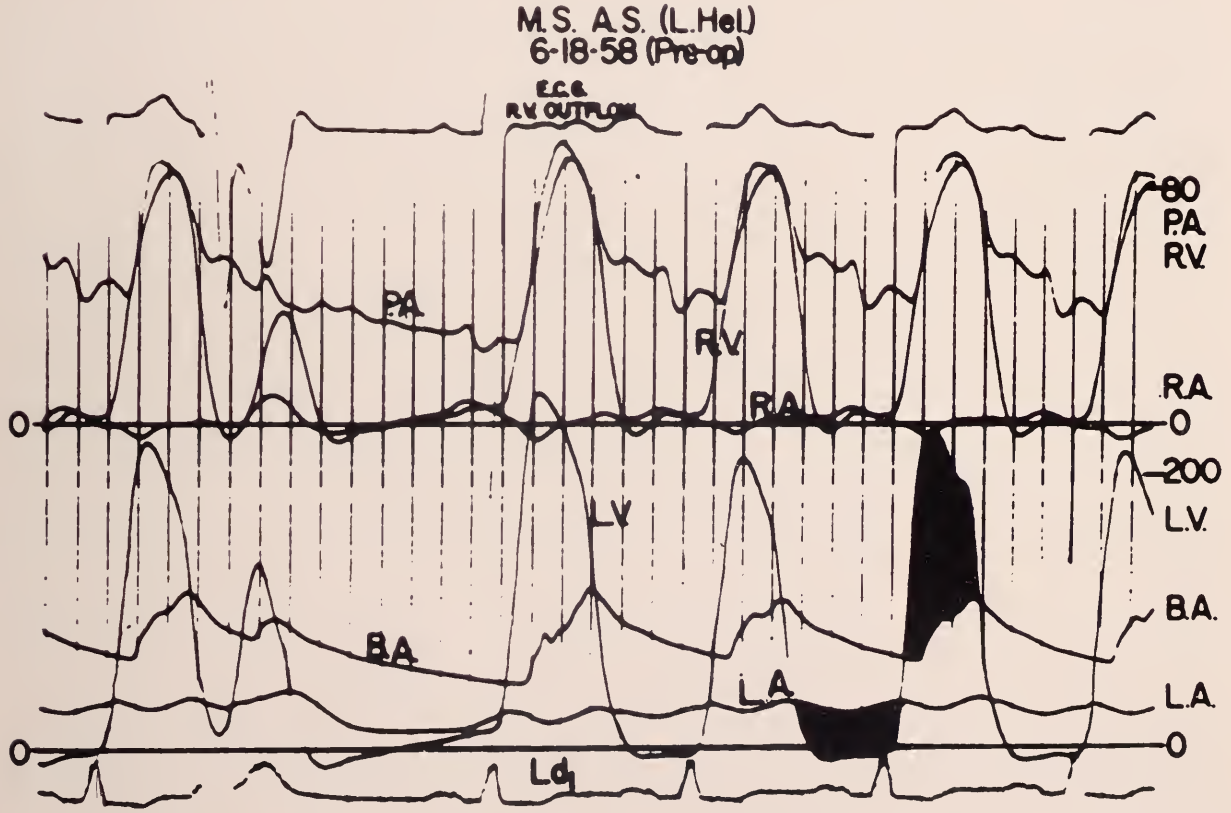
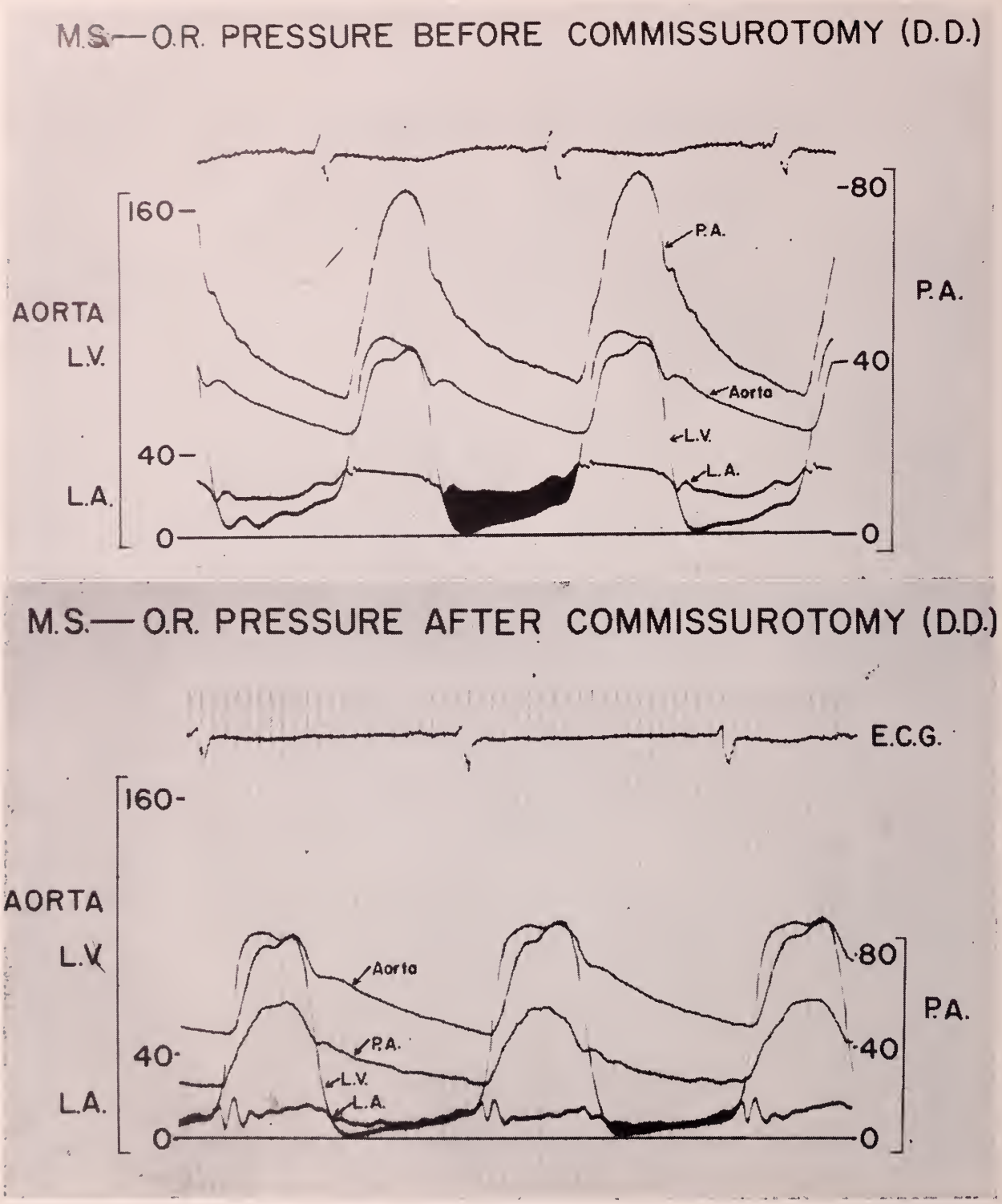


Fig. 8.—Simultaneous right atrial, right ventricular, pulmonary artery, left atrial, left ventricular and brachial artery pressure curves. The left ventricular systolic pressure is considerably greater than the brachial artery systolic pressure and the left atrial pressure is higher than left ventricular pressure in diastole. These findings are those of aortic and mitral stenosis respectively.



Figs. 9-10.—Operating room preoperative and postoperative pressure curves (figs. 9 and 10 respectively). Mitral commissurotomy results in disappearance of the mitral diastolic pressure gradient, that is, the diastolic pressure difference between left atrium and ventricle.

2a and b the tip was advanced from the right to the left atrium and thence back to the right atrium via a large interatrial defect. In figure 3a and b, the catheter tip was deliberately coiled in the right atrium. In figure 4a, b the catheter tip passed from the pulmonary artery to the descending aorta via a patent ductus arteriosus in a subject with pulmonary hypertension and reversal of flow through the ductus. In figure 5 the catheter tip passed from the right atrium into the inferior vena cava and thence into an anomalously draining right lower lobe pulmonary vein which emptied in-

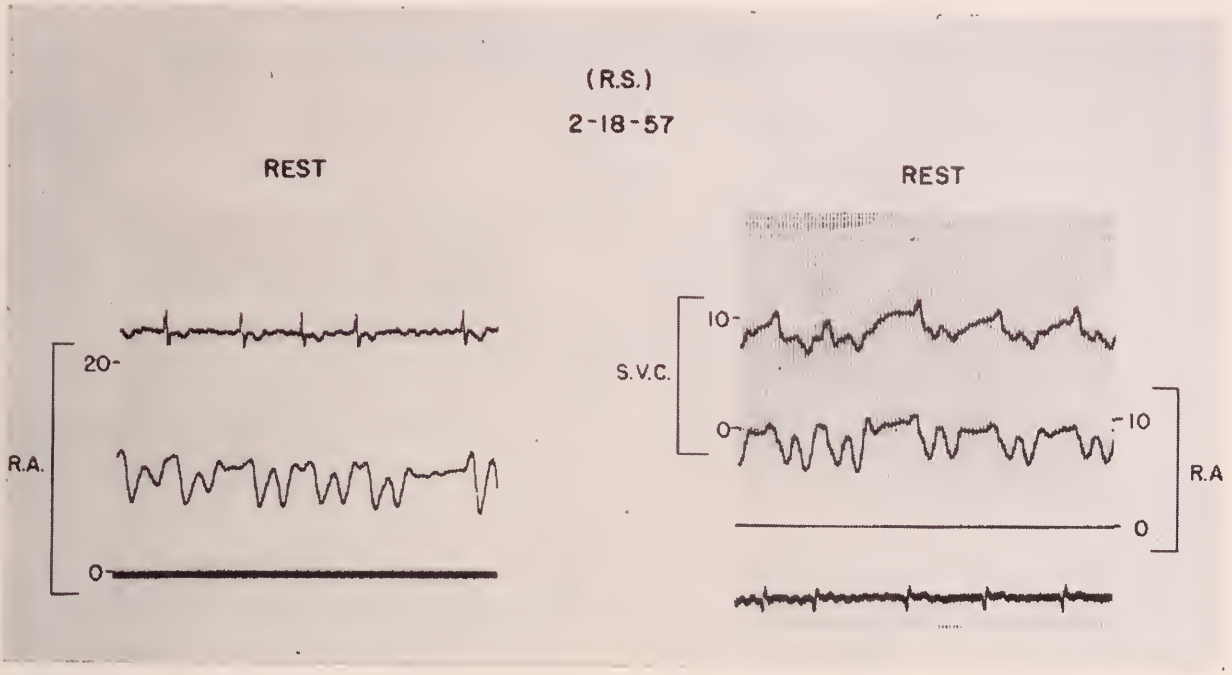


Fig. 11.—The characteristic "W"-shaped atrial and vena cava pressure curves in chronic contrictive pericarditis are shown.

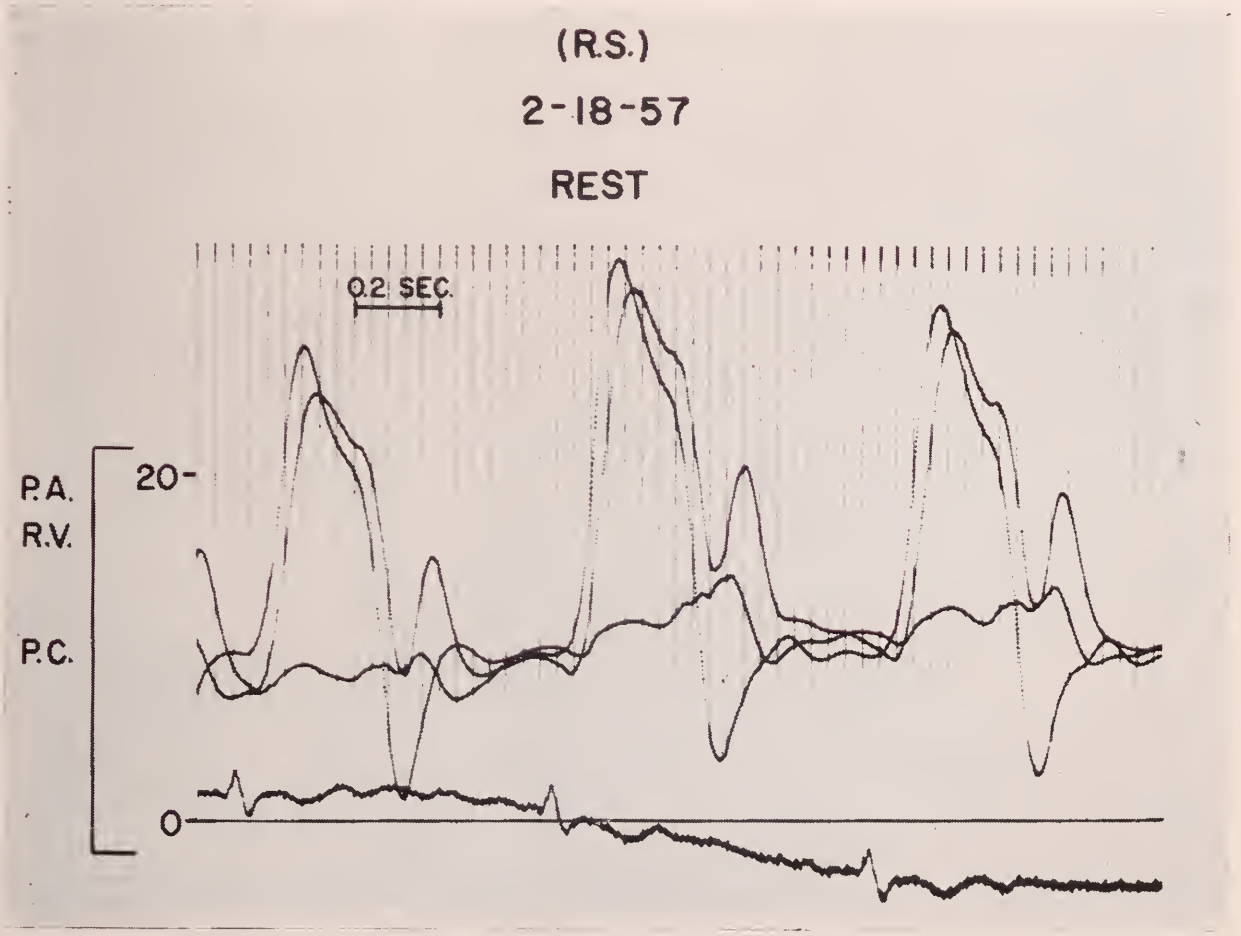
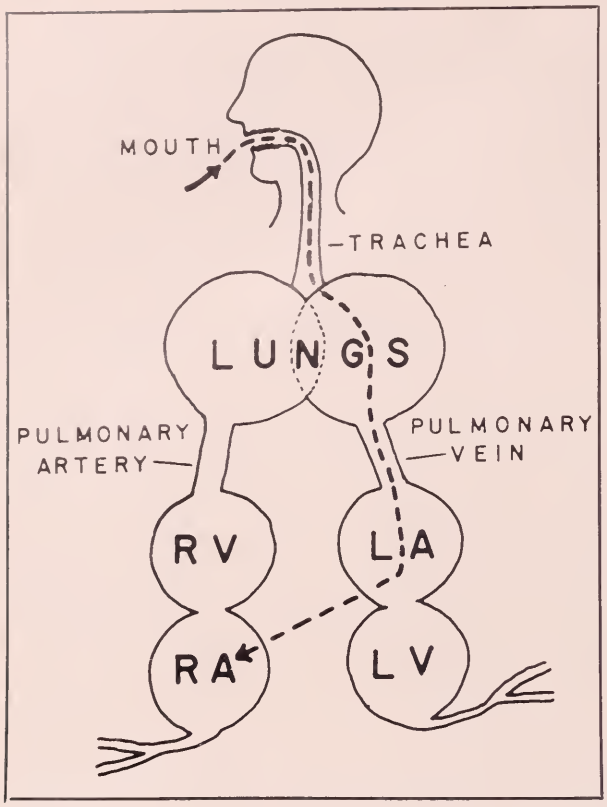


Fig. 12.—Pulmonary artery wedge, pulmonary artery and right ventricular pressure curves. The early diastolic dip in the latter curve is readily seen.



to the inferior vena cava rather than the left atrium. In figure 6a the tip has been wedged in a pulmonary vein which anomalously emptied into the junction of the right atrium and superior vena cava. In figure 6b the tip has passed from the right atrium into a dilated coronary sinus and into a left superior vena cava.

The diagnosis of physiologically significant valvular stenosis at either the atrioventricular or semilunar valve can be established with certainty by cardiac catheterization. In the normal subject the atrial and ventricular pressures are virtually identical in diastole; the ventricular and aortic

Fig. 13.—Foreign gas inhalation technique for determination of a left to right shunt. Simultaneous pulmonary artery and systemic artery samples are drawn for 20 to 30 seconds after onset of inhalation. In the absence of a left to right shunt, the ratio of pulmonary to systemic arterial concentration for this foreign gas is less than 10 per cent. In the presence of a left to right shunt the foreign gas will appear in increased concentration in the pulmonary artery sample by the mechanism indicated in the figure (for an interatrial septal defect).

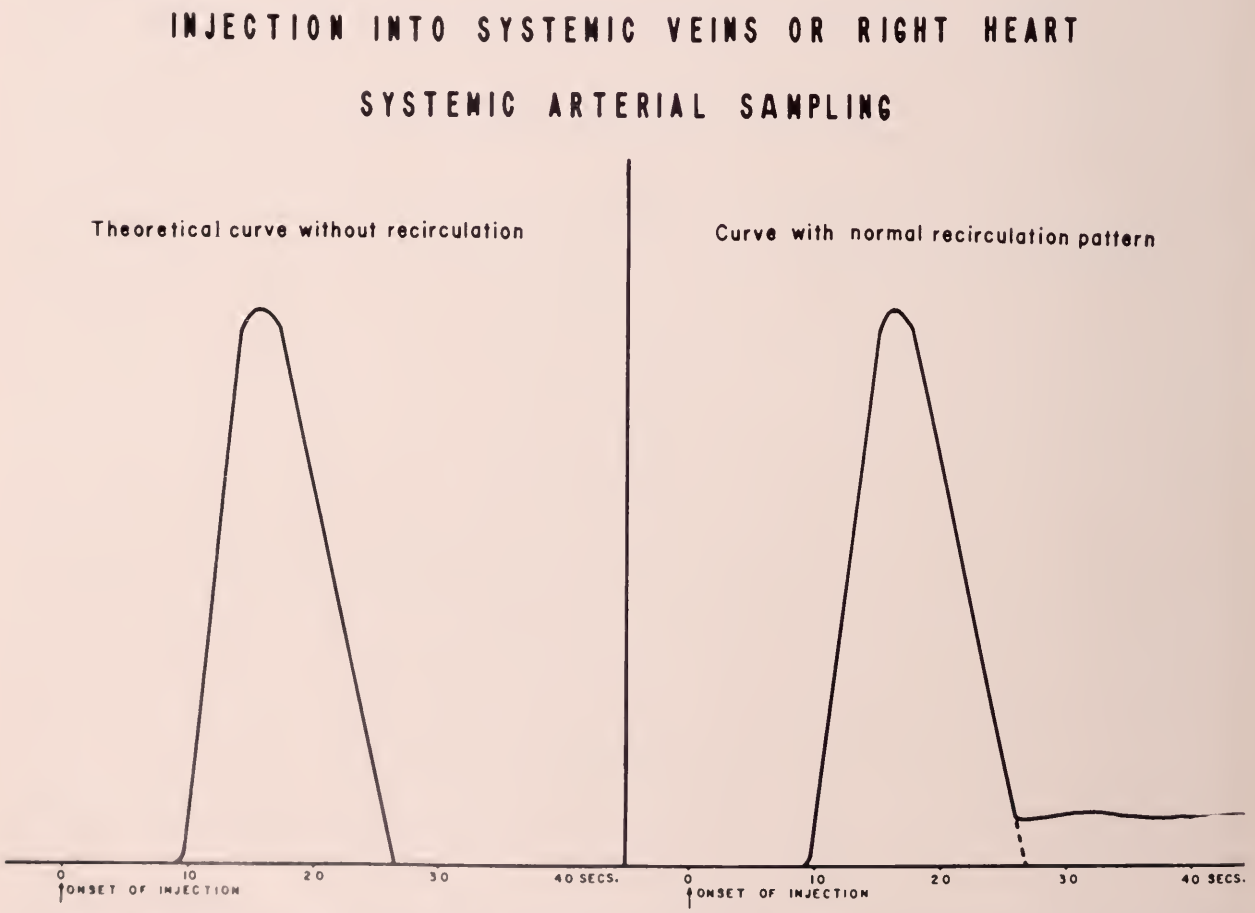


Fig. 14.—Schematic systemic arterial dye dilution curves after right heart indicator injection. The theoretical curve without recirculation is shown on the left. To the right is the actual in vivo dye concentration curve. The break on the descending limb of the dye curve is caused by dye recirculation.

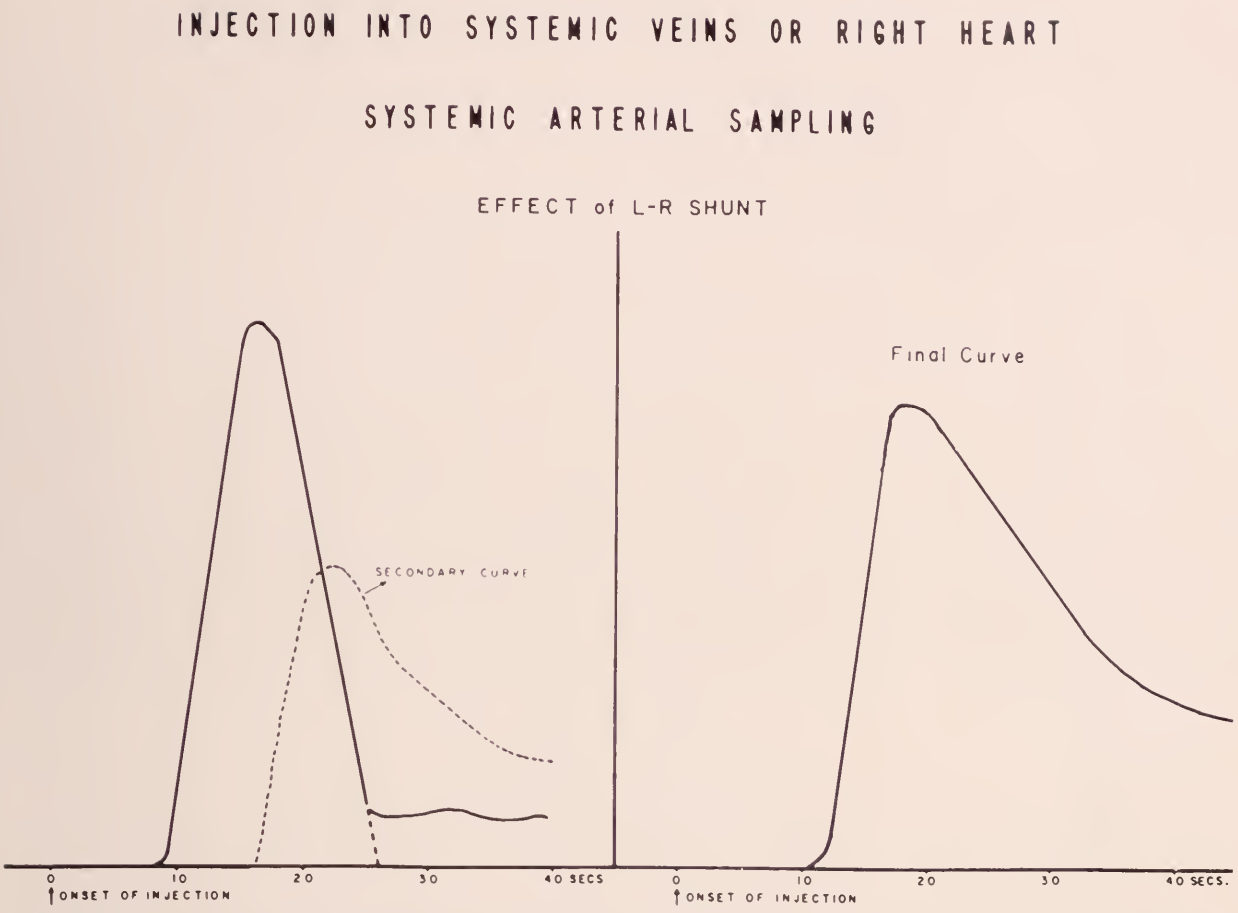


Fig. 15.—The effect of a left to right shunt on the shape of a schematic systemic arterial dye dilution curve is shown. The secondary curve is that caused by the left to right shunt. The shunt results in a lower peak concentration and prolonged disappearance curve. The sites of dye injection and sampling are indicated.

or pulmonary artery pressures are virtually identical in systole. In mitral or tricuspid stenosis, atrial pressure is elevated above the ventricular level in diastole; in semilunar valve stenosis, ventricular pressure is greater than great vessel pressure in systole. These relationships are illustrated in figure 7 and figure 8. The physiologic result of effective cardiac surgery is demonstrated in figure 9 and figure 10; the mean diastolic mitral gradient has been virtually abolished following mitral commissurotomy. Interpretation of the physiologic meaning of the magnitude of a valvular gradient is conditioned by the heart rate and cardiac output.[9] The latter is determined by the Fick principle via determination of oxygen consumption and oxygen concentrations in arterial and mixed venous blood, and by injection of an indicator substance such at T-1824 by the Stewart-Hamilton principle.

The atrial and ventricular pressure curves undergo characteristic (but not pathognomonic) changes in chronic constrictive pericarditis. These changes are illustrated in figure 11. The rhythm is atrial fibrillation. The atrial and superior vena cava curves become "W"-shaped. The second descending limb of the "W" is synchronous with the diastolic dip observed on the ventricular pressure curve (fig. 12).

The diagnosis of overriding aorta, that is, origin of the aorta from both ventricles (either on an anatomic or a physiologic basis) can be made by cardiac catheterization by determination of aortic (or systemic arterial) and right ventricular pressures. If the systolic pressure in these two chambers differs greatly, the diagnosis of overriding aorta is ruled out. If these pressures are similar or identical at rest and during exercise and during ventricular premature beats, the diagnosis of overriding aorta can be made with reasonable confidence. Direct passage of the catheter tip directly from the right ventricle into the ascending aorta affords further evidence for this lesion.

The diagnosis of intracardiac and extracardiac left to right and right to left shunts is readily made by right and left heart catheterization. This particular area of cardiac catheterization has pro-

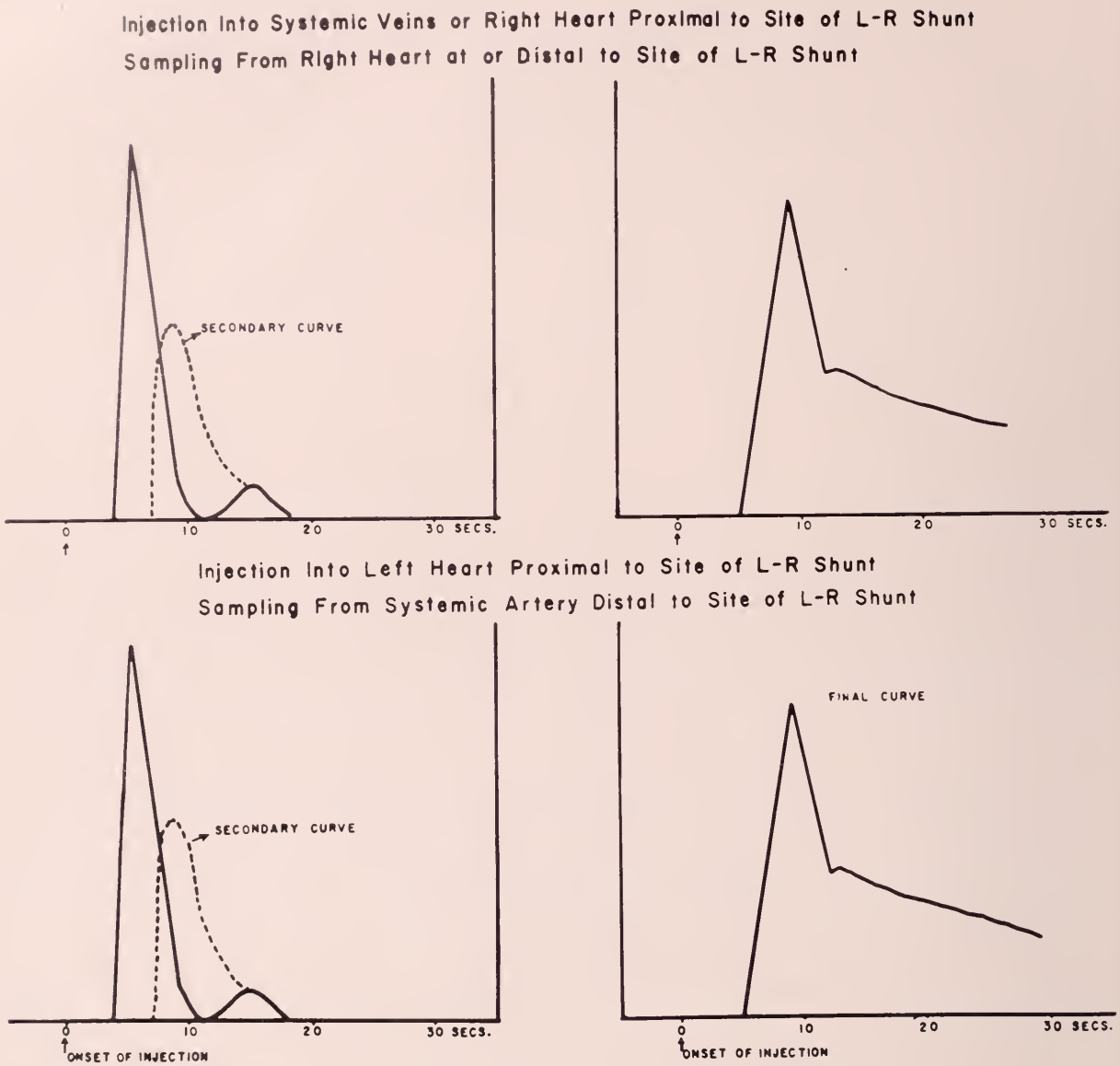


Fig. 16.—Demonstration of a left to right shunt by dye injection into the right heart proximal to the site of the shunt, with dye sampling distal to the shunt (upper half of figure); demonstration of a left to right shunt by dye injection into the left heart proximal to the site of the shunt with dye sampling distal to the shunt (lower half of figure). In either case, the descending limb of the dye curve is interrupted by the dye recirculating by the left to right shunt. The peak dye concentration is diminished by the shunt.

gressed most rapidly in the past few years. Traditionally, a left to right shunt has been diagnosed by the finding of an increased oxygen concentration in right heart venous blood (blood oxygen analysis is performed via Van Slyke manometric analysis and by ear or whole blood oximetry) as the catheter tip is passed from the right atrium to pulmonary artery. Because of the small oxygen extraction in the renal capillary bed, renal venous blood is less unsaturated than any other venous blood. Inferior vena cava blood therefore contains more oxygen than superior vena cava blood. The diagnosis of a left to right shunt at the atrial level is made when right atrial blood contains at least 2.0 volumes per cent oxygen more than superior vena cava blood; a shunt at the ventricular level is diagnosed when the right ventricular blood oxygen content is at least 1.0 volume per cent greater than right atrial blood; the corresponding diagnostic increment at the pulmonary artery level is 0.5 volume per cent. Since the systemic arterial-pulmonary artery oxygen difference is only about 4 volumes per cent normally, detection of a left to right shunt depends on detection of increments of right heart blood oxygen content of 4 volumes per cent at the maximum, superimposed upon a background pulmonary artery oxygen content of 12 to 14 volumes per cent. From a theoretical viewpoint this is poor analytical procedure.

Numerous newer techniques have therefore been devised to aid in more accurate determination of left to right shunts. These newer techniques should and do permit detection of smaller left to right shunts than is possible with the oxygen methods. The basic principles underlying these newer techniques[10-12] are illustrated in figures 13 to 15. The foreign gas inhalation technique is shown in figure 13. The gases employed are nitrous oxide, radioactive Kr^{85} and radioactive ethyl iodide containing I^{131}. In all three tests, the foreign gas is inhaled for about 30 to 40 seconds; during the last 20 to 30 seconds integrated samples are drawn from the pulmonary artery and a systemic artery. Normally the venous blood level of the foreign gas rises minimally during the test period while the arterial level rises rapidly. A foreign gas pulmonary artery blood to systemic artery blood concentration ratio of less than 10 per cent rules out a left to right shunt. If a shunt is found, the catheter tip is withdrawn to the right ventricle or right atrium and the study repeated to localize the site of the shunt. Since the normal foreign gas blood level is close to or actually zero, and the arterial level 3 to 5 volumes per cent (for nitrous oxide), the theoretical analytic basis for shunt detection is on a firmer base than for the oxygen study. Gas chromatograph nitrous oxide analysis and radioactive counting of Kr^{85} or I^{131} labeled ethyl iodide can be performed rapidly and permit completion of the analysis for shunt detection in less than five minutes. A further refinement of this approach has been recently described by Clark.[13] A special platinum black electrode (the electrode can be placed anywhere along the course of an ordinary cardiac catheter) catheter is prepared; if this electrode is placed in the pulmonary artery, a left to right shunt can readily be detected by inhalation of commercial tank hydrogen for one breadth. Early arrival of blood containing dissolved hydrogen at the pulmonary artery (via a left to right

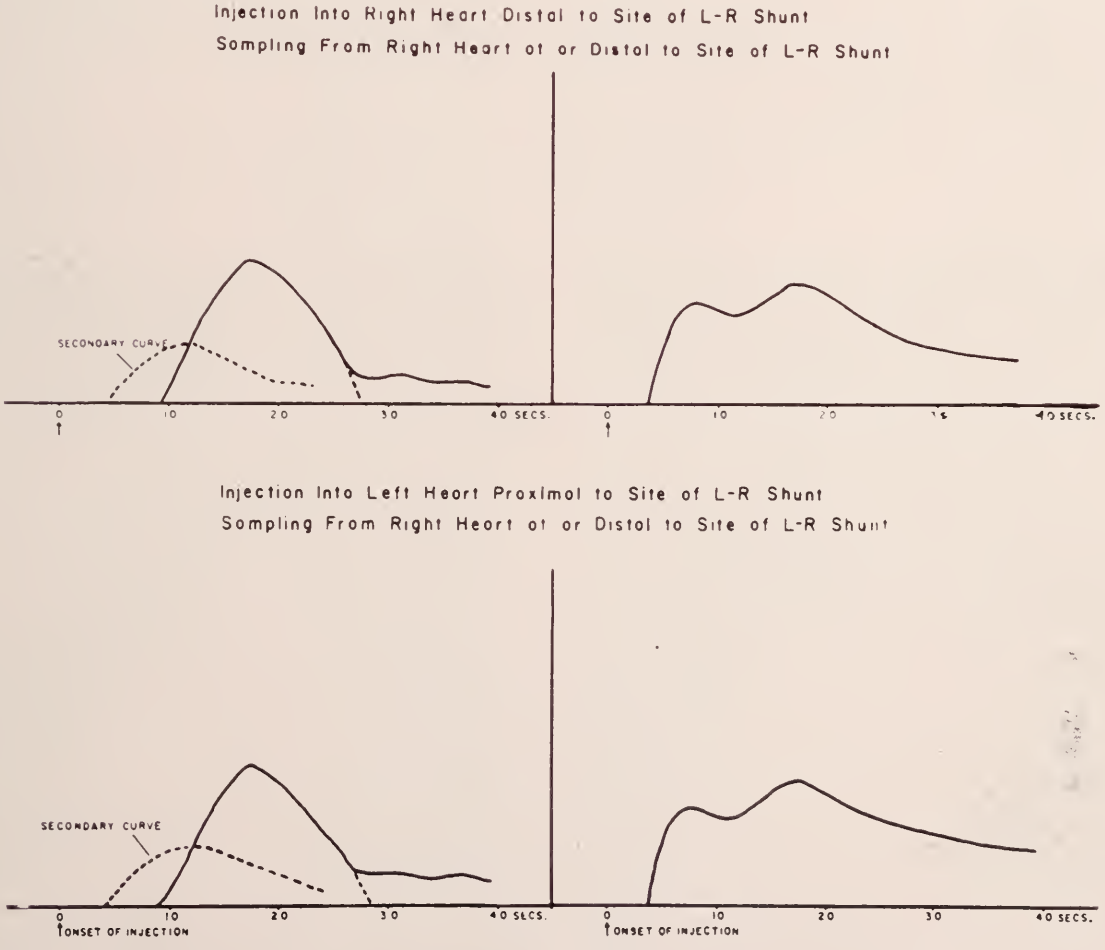


Fig. 17.—Demonstration of a left to right shunt by dye injection into the right heart distal to the site of the shunt with dye sampling at or distal to the shunt (upper half). Left to right shunt demonstration by dye injection into the left heart with right heart dye sampling (lower half of figure); in either case the dye curve is distorted by an early appearance time and by a double peak.

INJECTION INTO SYSTEMIC VEINS OR RIGHT HEART

SYSTEMIC ARTERIAL SAMPLING

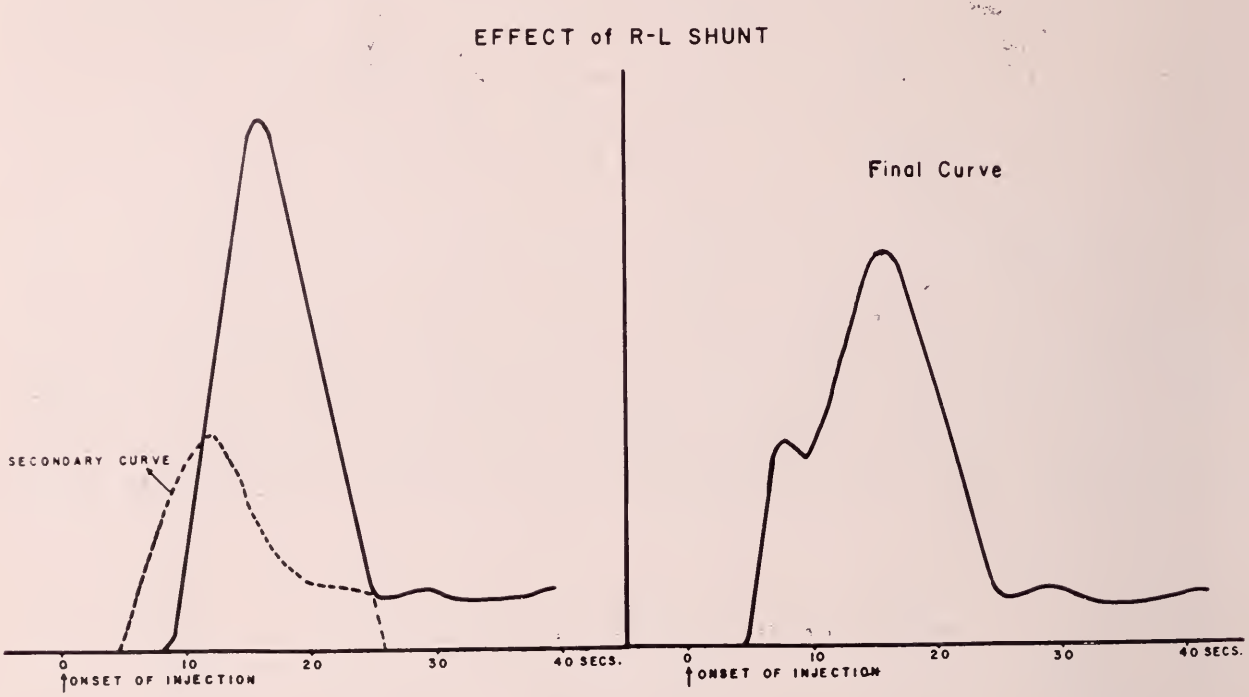
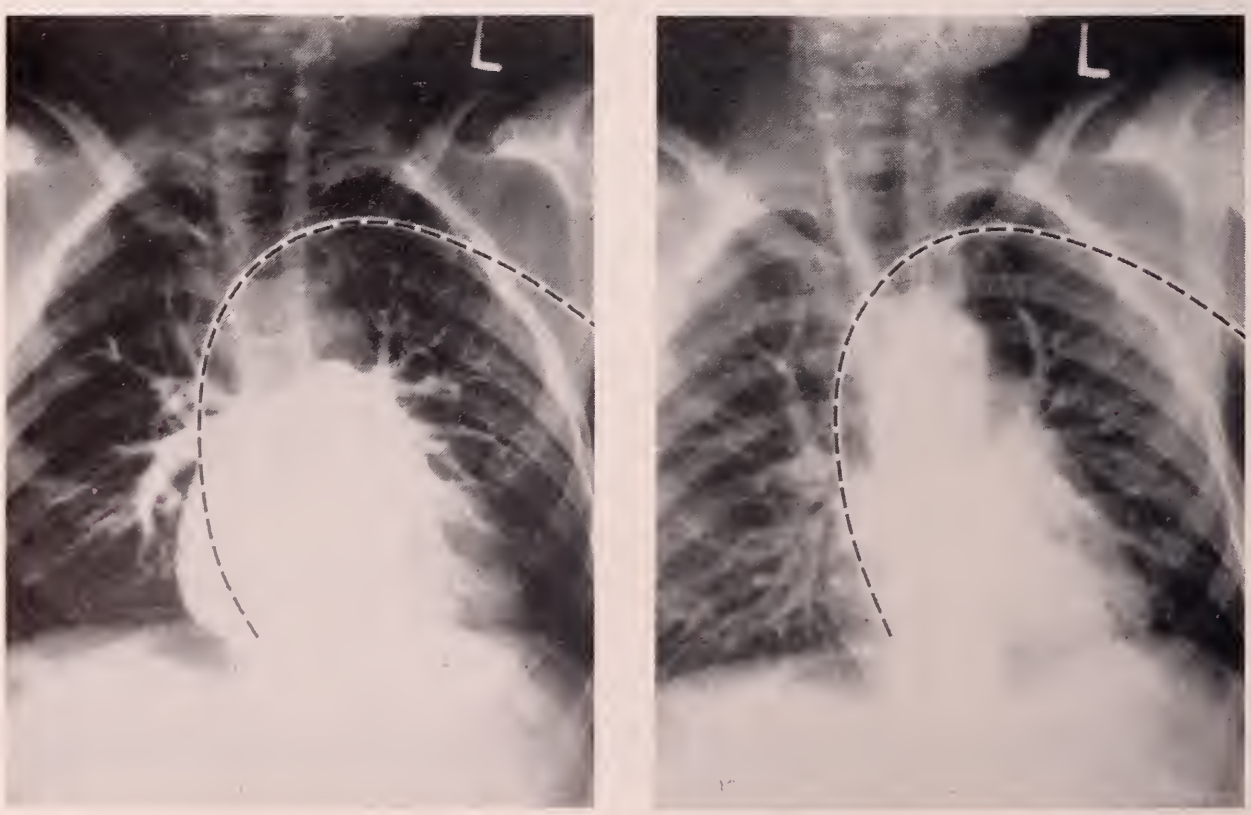


Fig. 18.—Demonstration of a right to left shunt by dye injection into the right heart with systemic arterial sampling. Two abnormalities are present in the dye dilution curve—an early appearance time and a double peak.



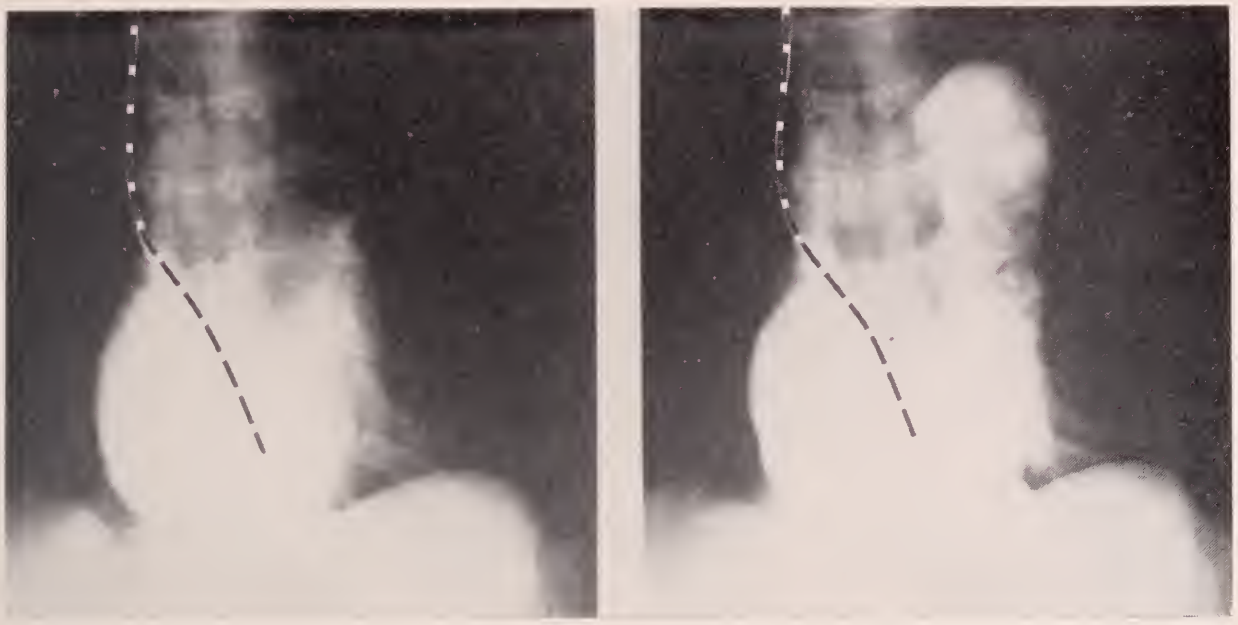


Fig. 21.—Idiopathic dilation of the pulmonary artery. Visualization of the right atrium and inflow tract of the right ventricle (left side) and the right ventricular outflow tract and pulmonary artery (right side). Note the sinuses of Valsalva of the pulmonary artery.

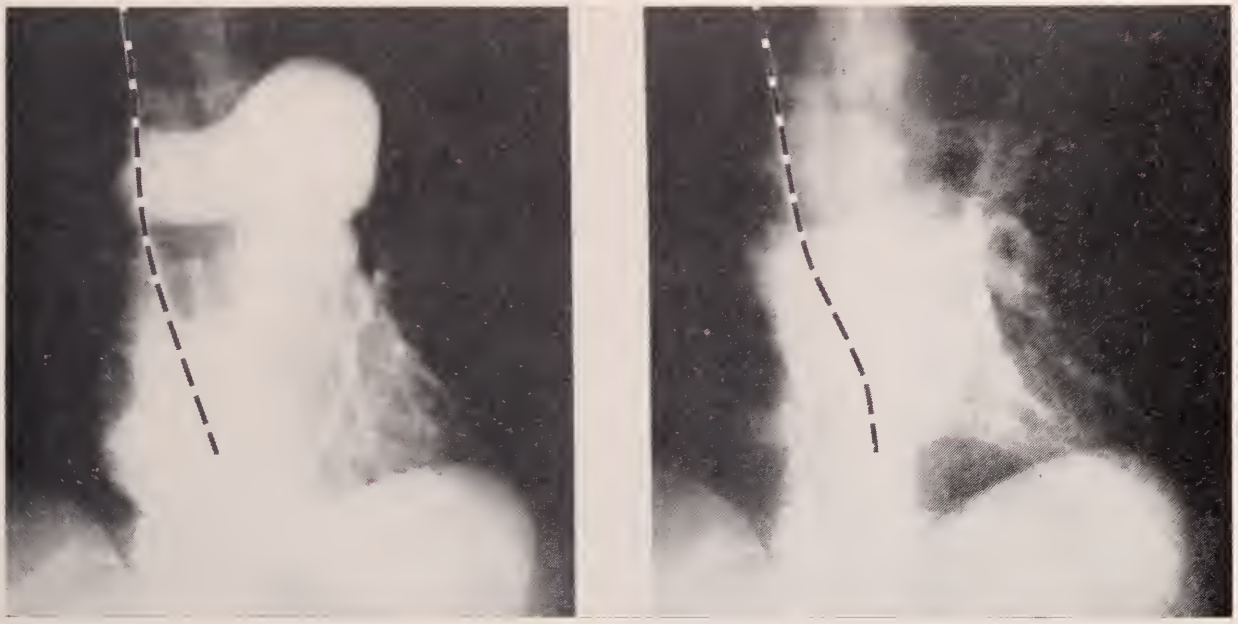


Fig. 22.—Same patient as in figure 21. The dilated pulmonary artery is visible on the left panel; the left atrium is filled on the right panel.

Opposite Page

Left

Fig. 19.—Right heart angiocardiogram showing filling of the right atrium, right ventricle and pulmonary tree in a normal child.

Right

Fig. 20.—Visualization of the left atrium, left ventricle and aorta in the same patient as in figure 19.

shunt) is readily detected by the platinum black electrode.

The use of dyes such as T-1824 and cardiogreen[14-17] to detect left to right shunts is illustrated in figures 14 to 17. The dye dilution patterns without and with a normal recirculation pattern are drawn in figure 14. The effect of a left to right shunt upon the dye dilution curve depends upon the site of injection and upon the



Fig. 23.—Same patient as in figure 21. The aorta and left ventricle are filled. The latter is in systole on the left panel and in diastole on the right panel.

sampling site. Some of the varied possibilities are outlined in figures 15 to 17.

Braunwald and Morrow[18] have also employed injections of solutions containing Kr^{85} into the left atrium to detect left to right shunts. In the absence of such a shunt, Kr^{85} does not appear in expired gas (which is continuously monitored for Kr^{85}) for 10 to 15 seconds. If a left to right shunt is present, Kr^{85} appears in expired gas in less than five seconds; right and left atrial Kr^{85} injections are performed in the same patient, the former serving as a control for the latter.



Fig. 24.—High right atrium in a young adult with Ebstein's disease.

Right to left intracardiac or extracardiac shunts may also be detected in several ways. Arterial oxygen unsaturation, especially if only partially corrected by inhalation of 100 per cent oxygen, is evidence of such a shunt. Passage of the catheter tip from the right heart to the aorta in the presence of right ventricular or pulmonary artery pressures at systemic levels also suggests a right to left shunt. Dye curves may also be employed to detect a right to left shunt (fig. 18). Dye injection into the right heart proximal to the site of a right to left shunt is followed by premature appearance of the indicator substance in blood samples from a systemic artery.[19] Kr^{85} may be employed in a similar fashion to detect right to left shunts.[18] Since over 95 per cent of Kr^{85} injected into the right heart is normally excreted into the lungs and removed by the respiratory process in one circulation, the appearance of significant amounts of Kr^{85} in arterial blood after intravenous injection is suggestive of a right to left shunt.

These dye techniques may also be employed in the detection and diagnosis of valvular regurgitation by injection into the chamber distal to the valve with simultaneous sampling from the chamber just proximal to the valve. In the absence of regurgitation, dye does not appear in the proximal chamber for 10 to 15 seconds. In the presence of regurgitation, dye appears in the proximal chamber within a few seconds after injection.

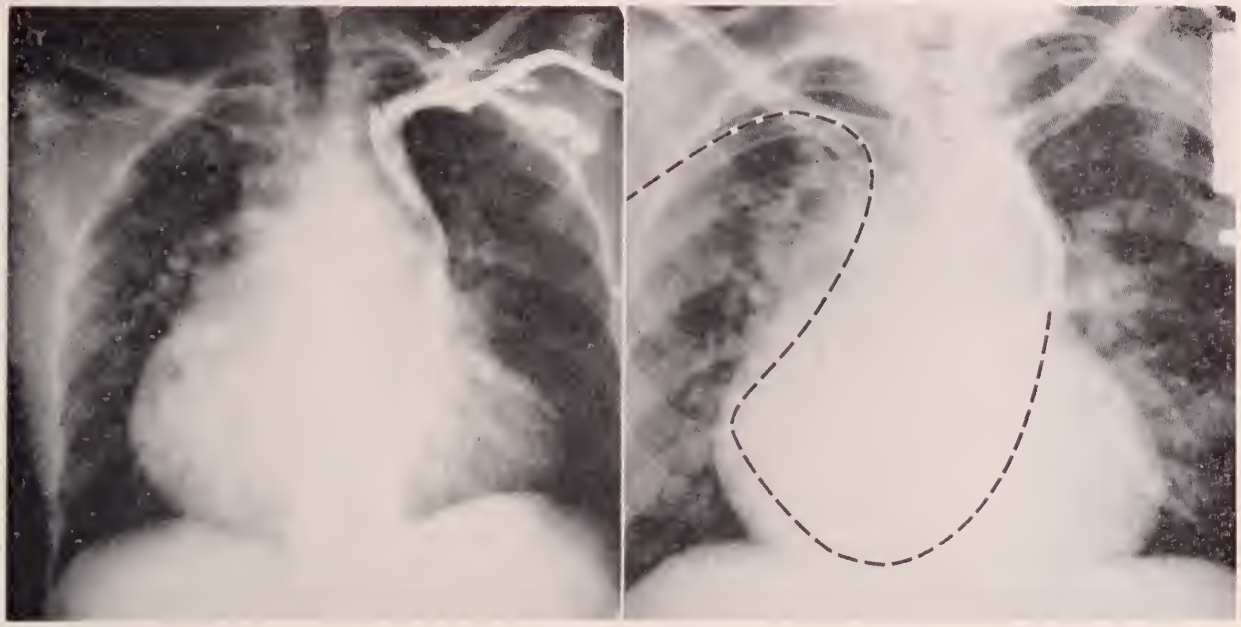


Fig. 25.—a. Left upper extremity peripheral vein dye injection outlining a left superior vena cava emptying into the right atrium via the coronary sinus; same patient as in figure 6b. b. The persistent left superior vena cava has been outlined by radiopaque dye injected through an intracardiac catheter; the catheter tip is in the left superior vena cava.

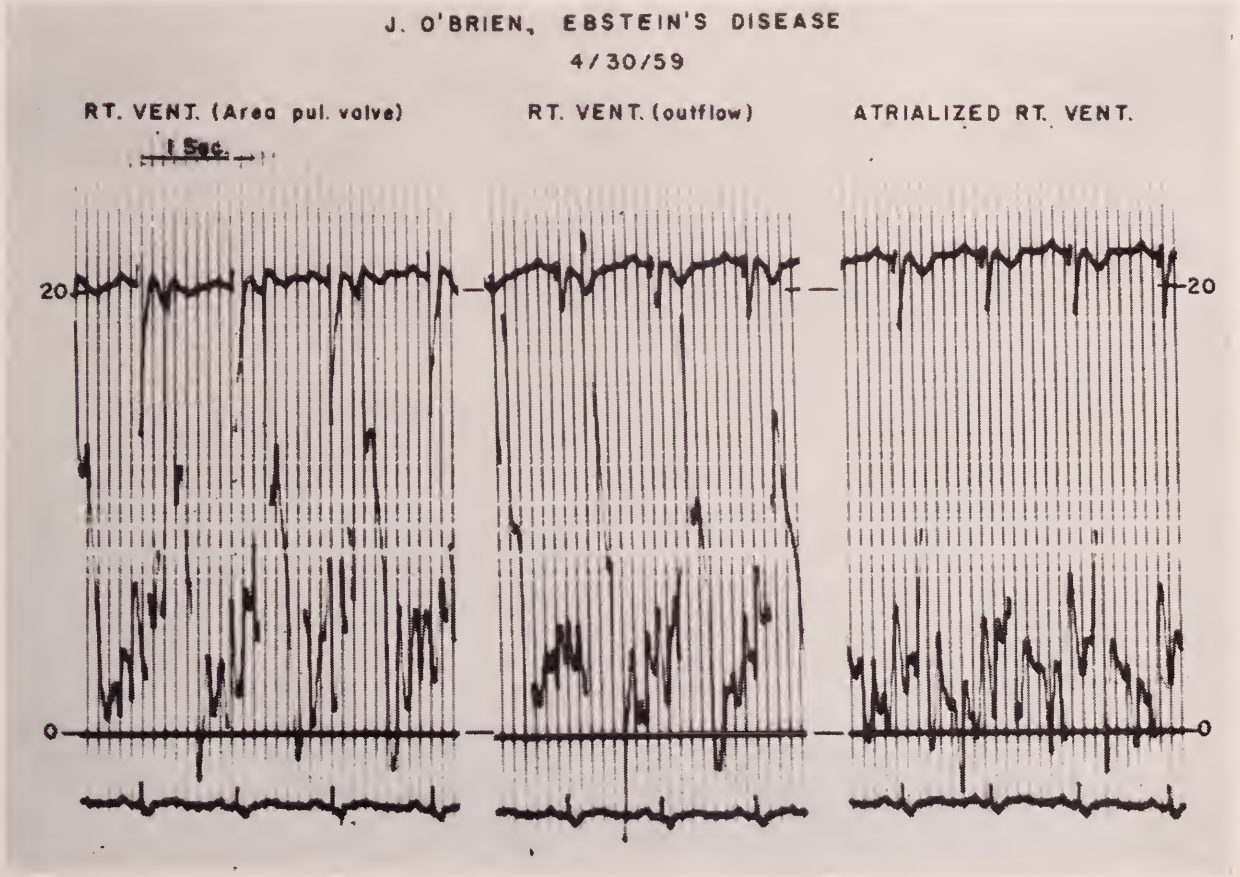


Fig. 26.—The uppermost curve is an intracardiac electrocardiogram recorded from the catheter tip, the middle of a pressure curve and the lowermost, lead 1. The pressure curve changes from a ventricular curve (labeled Rt. Vent., left 2 strips) to an atrial curve (atrialized Rt. Vent., in the right side strip) without a change in the intracardiac electrocardiogram in the middle and right strip.

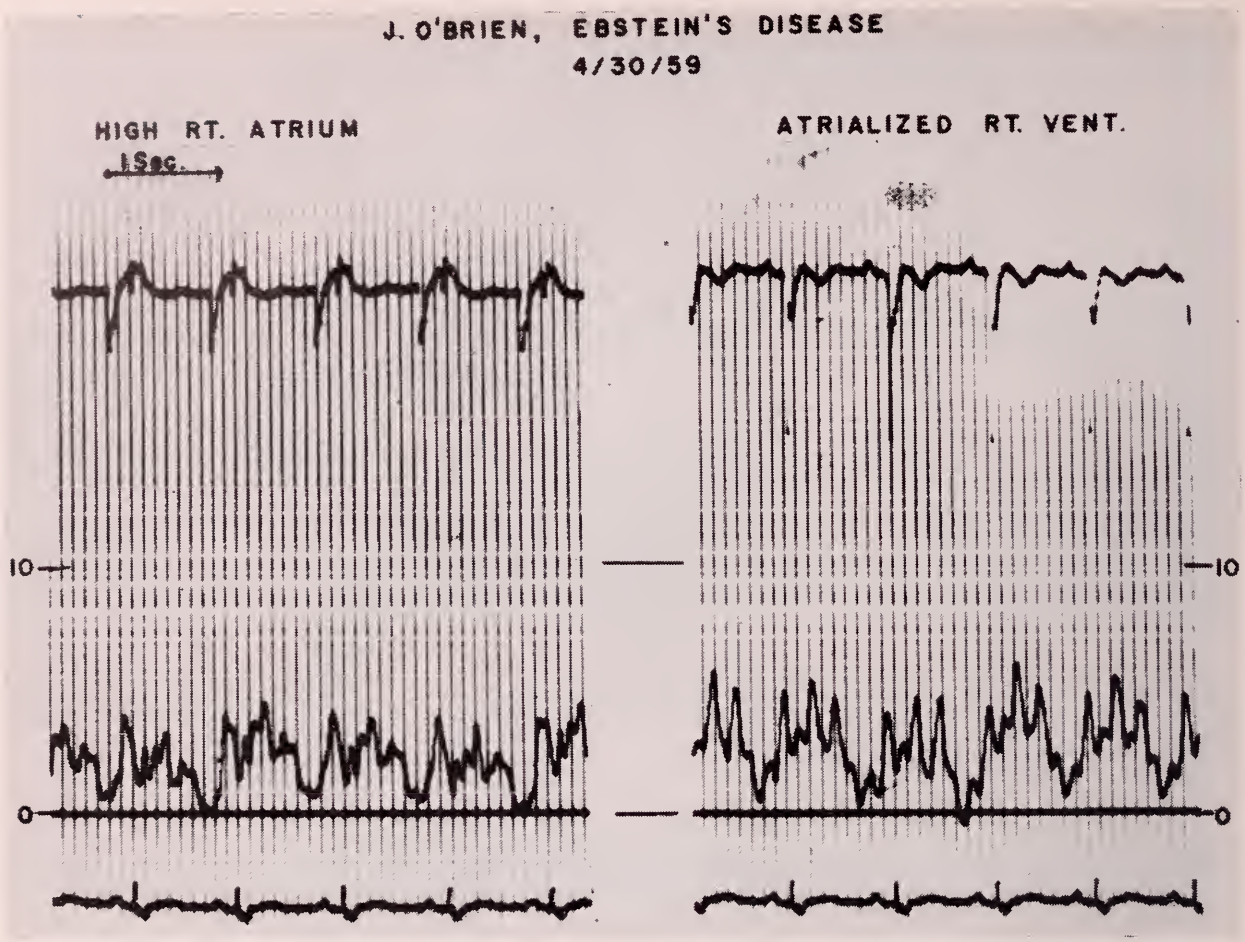


Fig. 27.—The three curves are as in figure 25a. Both pressure curves are atrial in form. On the left side the major electrocardiographic wave in the right atrium is the large downward P wave; the QRS deflection is much smaller. On the right side, the QRS complex forms the major electrocardiographic deflection, as is characteristic of the right ventricular electrocardiographic pattern. The pressure curve, however, is atrial in character in both strips.

Angiocardiography

Angiocardiography has been of great aid in the diagnosis of congenital and acquired heart disease. Varied techniques have been employed, ranging from intravenous injection via one antecubital vein to selective angiocardiography with intracardiac injection using a pressure injector and a biplane multifilmer taking up to 12 films per second in each plane. The development of selective angiocardiography has permitted visualization of considerably more anatomic detail than formerly possible. Right and left heart visualization in a 10 year old normal child after right atrial injection using 20 ml. of 90 per cent Hypaque is shown in figures 19 and 20. A special pressure injector* was employed in this study. Visualization of the right and left heart and the dilated pulmonary artery in idiopathic dilation of the pulmonary artery in man (figs. 21-23) demonstrates the anatomic detail readily available with this technique. The high right atrium in Ebstein's disease is seen in figure 24. A left superior vena cava is outlined with radiopaque dye in figure 25. The role of the image amplifier employed in conjunction with a motion picture camera has been outlined.

Left heart selective angiography has been employed in the diagnosis of mitral and aortic insufficiency.[20] Left ventricular puncture with subsequent radiopaque dye injection will demonstrate dye backflow into the left atrium in mitral insufficiency. Dye injection into the ascending aorta near the aortic valve will visualize the left ventricle in aortic insufficiency.

Several other procedures are worthy of note. Intracardiac electrocardiography with a German silver electrode located near the catheter tip opening is especially useful in Ebstein's disease. The normal intracardiac electrocardiographic pattern on the right ventricular side of the tricuspid valve

* Developed by Drs. William P. Murphy Jr. and Robert J. Boucek, Section of Cardiology, Department of Medicine, University of Miami School of Medicine.

is readily differentiated from that on the right atrial side of the valve. In the former instance, the QRS height is usually 50 to 100 mm. and the P wave is small. On the atrial side, the QRS complex is much smaller, but the P wave becomes prominent with a predominantly positive deflection. The atrial electrocardiographic pattern is associated with an atrial pressure curve; the ventricular electrocardiographic pattern is associated with a ventricular pressure curve. In Ebstein's disease part of the right ventricle is "functionally atrialized;" as a result, on the ventricular side of the tricuspid valve, an atrial type of pressure curve may be recorded simultaneously with a ventricular electrocardiographic pattern[21] (figs. 26 and 27). Intracardiac phonocardiography employing "activated" barium tannate as a microphone has been employed by Lewis and his associates[22] to localize the origin of heart sounds and murmurs. This technique offers great promise for the future.

Bronchospirometry has been employed in a subject with partial (complete unilateral) anomalous pulmonary venous drainage to demonstrate the existence of this lesion.[23] Administration of pure nitrogen to the right lung only (the side of the total unilateral anomalous pulmonary venous drainage) produced no change in arterial oxygen saturation while the other lung inhaled room air. Reversal of the gas mixtures to the two lungs resulted, of course, in a rapid fall in arterial oxygen saturation. This technique may be employed whenever pulmonary venous drainage is significantly different in the two lungs.

Balloon cardiac catheters have been employed in an attempt to estimate the size of an interatrial septal defect.[24] The deflated balloon is passed via a catheter tip into the left atrium. The balloon is then inflated with radiopaque dye. Attempts are then made to withdraw the balloon back into the right atrium. The largest balloon size which permits passage of the balloon from left to right atrium provides an estimate of the size of the interatrial septal defect.

Summary

Some of the recently developed clinical and laboratory aids in the diagnosis of congenital and acquired heart disease are outlined. These contributions to diagnostic cardiology have proved of considerable value in the daily practice of both pediatric and adult cardiology. The great contributions of cardiac catheterization and angiocardiography are emphasized because it is our belief that the development of cardiac surgery has increased and continues to increase the indications for these procedures. At some time in the future, clinical experience and acumen may obviate the necessity for some of these studies, but that time is not yet at hand.

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The Ophthalmologist Fitting Contact Lenses

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The widespread popularity of contact lenses is creating an ever increasing demand on the part of the public for this service. This situation has posed quite a dilemma for the medical profession, and particularly for the ophthalmologists. To be blunt, if we do not provide good contact lens service, the public will think that we have been negligent. As a therapeutic agent, contact lenses have a wide application and are indicated for use in various situations listed in a previous paper.[1] This wide application of use affects a high percentage of ophthalmic patients.

There are several aspects of this work that are worthy of discussion as they relate to practice management and patient relations. The most important one to remember is that this work has excited great public enthusiasm, and all too often the patients are confronted in the busy ophthalmologist's office with some degree of indifference. Whether the individual practitioner cares to embark in this new field or not, he should not cast a pall of doubt or indifference over a patient's desire for contact lenses.

Suffice it to say that the practitioner who has no desire to get into this field of work should at least be reasonably well informed on the subject so as to be able to refer these patients to medical colleagues who can perform the service competently. The remainder of this discussion will therefore be devoted to several pertinent points of interest to the ophthalmologist who wishes to perform this service himself.

Problems

Training presents the first problem because there are no formal courses of instruction presently available in medical institutions. The clinical experience must largely be gained from trial and error. As yet there are no published textbooks by physicians on the subject, and only a few papers have appeared in the literature. It is safe to say that as yet the official policy of the optometric organizations is to prohibit their members from giving their instruction to physicians.

Read before the Florida Society of Ophthalmology and Otolaryngology, Jacksonville, April 10, 1960.

To this challenging problem there are solutions. Let us first agree, however, that unless a man doing this work makes himself thoroughly capable, he is being unjust to his practice and himself. There are ways for the ophthalmologist who wishes to pursue this work to train himself competently, if he is willing to pay the price.

The first prerequisite is a complete knowledge of the cornea, the prime reason really why only ophthalmologists can best perform contact lens service. Instruction in the fitting and adjustment of the lenses is now available from the larger lens manufacturers and usually consists of three weeks' study courses.

Development of clinical proficiency can be gained from performing the service on interested patients from one's own practice by careful choice of cases, though in many of these cases the service will be performed at no profit. This method is trying, but serves the purpose. Experts agree that 100 successfully treated cases of all types are required to gain reasonable clinical experience.

Sufficient time should be allotted these cases to be able to study them as well as the technical aspects of lens design, fitting, and adjustment and development of tolerance. The practice of relegating parts of this work to auxiliary personnel leads to disastrous results, and is damaging to the doctor-patient relationship.

An investment for equipment and materials is also required. Because of the time required to develop the necessary skill, learn the work, and establish a reputation for this work, this equipment and material investment cannot be expected to be recovered rapidly.

With the basic lens instruction and materials and equipment obtained, starting clinical cases is the next step. In a busy ophthalmic practice one potential contact lens patient per week should be a conservative average. If there is an interest expressed by a patient, or a question asked about contact lenses, barring other contraindications, this patient should be treated. Such patients plus

their referrals will constitute the first hundred patients.

Correlation of these facts allows a projected estimate of success based on other practitioners' experience. A 25 per cent failure record in this hundred patients will be average, though later a success of 90 per cent may be expected.

As a practitioner's experience increases, his selection of cases will be more critical and his skill at patient management during the tolerance period will lessen his failure record. The ophthalmologist should also develop his own skill in trouble shooting his cases and in making his own lens adjustments. The skill of diagnosing and correcting lens problems greatly increases patient tolerance and wearability.

If the ophthalmologist is capable of adjusting lenses, patient acceptance and confidence are greatly increased, and much inconvenience and time are saved. This is not a difficult matter if the proper equipment is at hand and is efficiently arranged.

Summary

In summary, this brief discussion highlights several points to which ophthalmologists must give serious consideration:

1. Contact lens service is a valuable and popular form of therapy.

2. No ophthalmologist can safely afford to consider contact lens service as only a "side line," but if he performs it, he must apply his time and effort unsparingly.

3. Public demand for contact lens service will continue to expand.

4. Adequate instruction must be incorporated into medical educational programs to provide better training for service in this field.

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Prednisone Therapy in Infertility

Report of Case

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The idea that cortisone might be effective in the treatment of hirsutism was first suggested by Whitaker and Baker.[1] Menstrual disorders, including amenorrhea, oligomenorrhea and menometorrhagia, responded remarkably to prednisone administration. This response was shown earlier by Jones, Howard and Langford,[2] Greenblatt[3] and others employing cortisone. The mechanics of improvement are not clear; whatever the explanation, clinical results are gratifying.

Report of Case

A 30 year old white, married woman was first seen on March 2, 1957 with the chief complaint of sterility and of having a generalized skin rash. She had been married since 1953. She stated that she had had a complete gynecological study, including a Rubin's test and sperm studies of the husband, with normal results. There was a history of a possible pregnancy with abortion at the age of 18. No contraceptives had been used since her marriage. The skin eruption, although always generalized, was especially severe on the back, presacral region, chest, perineum, antecubital surfaces, and popliteal areas, and was weeping continuously. The menarche occurred at the age of 14. During the first year the menses were irregular, with periods of amenorrhea. The patient had always had small breasts and at the age of 13 began to note hirsutism about the nipples and abdomen. After the first year, the menses occurred regularly every 26 to 30 days, lasting one to three days, with oligomenorrhea and cramps. Facial acne had been marked from the time of the menarche until prednisone treatment was instituted. There was known allergy to sulfonamides, penicillin, seafoods and tomatoes. There was no history of difficulty with libido.

The patient had three sisters and five brothers. One sister, aged 39, Gravida I, Para I by cesarean section, had always had menorrhagia and difficulty conceiving. Another sister, aged 33, married four years, had irregular menses and no history of pregnancies. The third sister, aged 32, Gravida V, Para IV, had menorrhagia. The mother, Gravida IX, Para IX, had no history of gynecologic disorder.

Physical examination revealed a 30 year old, well nourished, underdeveloped white woman with a blood pressure of 118 mm. Hg systolic and 62 mm. Hg diastolic,

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weight 119 pounds and temperature 98.4 F. A grossly weeping dermatitis was present about the neck, arms, fingers, perineum, legs, presacral area and groin. This generalized rash was eczematous in type with erythema, excoriation and weeping confluent lesions. Also present were 4 plus facial acne and 2 plus periareolar and lower abdominal hirsutism. The voice was that of a masculine low-pitched voice. The mammary glands were underdeveloped with no evidence of striae. The patient appeared apprehensive and withdrawn.

Bimanual examination revealed a masculine pubic hair line. The external genitalia were normal; the introitus was marital, the clitoris of normal size, the cervix pink and infantile, and the uterus small, firm, regular, retroverted 2 degrees and freely movable. The right ovary was palpable and twice the size of the left normal-sized ovary.

Papanicolaou smears were reported as negative for abnormal cells; vaginal smears revealed hypo-ovarianism; the basal temperature chart failed to give evidence of ovulation. The patient was given chorionic gonadotropin, 400 units twice weekly for six weeks. The menses that followed were of 28 day cycles and good flow, lasting three to five days, and the rash was slightly improved, but there still was no evidence of ovulation.

When the patient was first seen in 1957, she was being treated by a dermatologist and was receiving ACTH, 40 units weekly, following which she noted aggravation of the dermatitis and menstrual cycle. In June 1958 the ACTH was discontinued by the dermatologist.

In July 1958 Enovid, 10 mg. daily, was prescribed cyclically for three months. After Enovid was discontinued, the menses were regular every 28 days, lasting four days, but there continued to be no evidence of ovulation.

In January 1959, the total 17-ketosteroid level was reported as 6.8 mg. in 24 hours. Repeat total 17-ketosteroid levels were reported as 16.4 mg. in 24 hours. The creatinine level was checked to evaluate the validity of the 24 hour specimen; this level was 1.78 Gm. in 24 hours.

In February 1959 the patient was given 4 mg. of prednisone twice a day for 30 days, then 4 mg. daily. The rash began to clear after one week of prednisone therapy. She could now eat the foods to which she had previously been allergic. The facial acne cleared. The menses occurred every 28 days, lasting four or five days, with normal flow and no cramping or clotting. The breasts began to enlarge two months after initiation of prednisone therapy, and there was evidence of ovulation by the basal temperature chart. The voice changed to the typical female high pitch. The last normal menses occurred on July 8 with onset of presumptive signs of pregnancy three weeks thereafter. The reaction to the Friedman test was positive on August 24.

During the antepartum course, the rash remained clear as long as prednisone therapy was maintained at 2 mg. daily. Attempts to discontinue prednisone brought on recurrence of the rash. The antepartum course was complicated by two bouts of what appeared to be renal colic on the right side. Cystoscopy by the urologist revealed an unobstructed right ureter. The patient was not subjected to radiography. There were no noted blood pressure changes. The gain in weight in the last two years was 6 pounds, with no change in weight since prednisone treatment was instituted. The patient is now in the twenty-second week of gestation with the expected date of confinement April 14.

Summary

A case of infertility is reported in which prednisone therapy produced gratifying results.

Addendum: Since the presentation of this report, the patient was delivered vaginally on April 16, 1960 over midline episiotomy, after eight hours of uncomplicated labor, of a viable healthy female infant, weighing 6 pounds, 14 ounces.

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ABSTRACTS

Nutritional Megaloblastic Anemia Associated with Sickle Cell States. By Ulfar Jonsson, O. Stuart Roath and Charlotte I. F. Kirkpatrick. Blood 14:535-547 (May) 1959.

Three cases are reported in which nutritional megaloblastic anemia was observed in patients with sickle cell disease or sickle cell-hemoglobin C disease. Other cases of megaloblastic anemia occurring in the course of hemolytic anemias are reviewed and possible etiologic relationships discussed. It is concluded that the megaloblastic blood formation in such patients may be due to excessive need for folic acid or vitamin B_{12}.

Tricuspid Atresia: A Case Report of a 51 Year Old Woman Treated by an Extracardiac Shunt. By Francis N. Cooke, M.D., and Francisco A. Hernandez, M.D. South. M. J. 52:1016-1018 (Sept.) 1959.

A case of tricuspid atresia is presented in which the patient had survived to the age of 51, and even had married and been delivered of a normal, although premature, child at the age of 41. She was operated upon because peripheral arterial oxygen saturation had dropped over a period of five years from 84 per cent to 75 per cent with increase in the hematocrit level requiring frequent phlebotomies. At operation, a Dacron prosthesis was sutured first to the pulmonary artery and then to the aorta just below the subclavian take-off. The patient tolerated the shunt well, and for 12 months her course has been most gratifying. The arterial oxygen has risen to 86 per cent, and the hematocrit level is now normal. The authors hope that their experience with this patient will encourage others to take a more hopeful view of some patients of this type in an age group in which surgery is ordinarily not considered.

Sickle Cell-Hemoglobin C Disease. Report of a Case Associated With Sudden Coma in the Puerperium. By R. G. Alper, M.D., D. Cavanagh, M.D., and Ulfar Jonsson, M.D. Obst. & Gynec. 13:319-324 (March) 1959.

Pregnancy in patients with sickle cell anemia is associated with a markedly increased maternal and fetal mortality rate. Less well known is the fact that in patients with the combined inheritance of sickle cell hemoglobin and hemoglobin C who have been asymptomatic and only slightly anemic, serious complications may develop during pregnancy and the puerperium. To emphasize the dangers of sickle cell-hemoglobin C disease complicated by pregnancy, the authors report the case of a 24 year old Negro woman with this disease who suddenly became comatose 30 hours after normal delivery but recovered after several weeks. They present a brief review of similar cases in which the patient died suddenly during pregnancy or the postpartum period. Pathogenesis, prevention, and treatment of these conditions are discussed. It is concluded that probably many of the cases reported in the literature as deaths during pregnancy in patients with sickle cell anemia or trait are cases of sickle cell-hemoglobin C disease.

Spontaneous Regression of Human Melanoma. Clinical and Experimental Studies. By Wilbur C. Sumner, M.D., and Alvan G. Foraker, M.D. Cancer 13:79-81 (Jan.-Feb.) 1960.

The authors had the opportunity to observe two patients with comparatively long term regression of proved malignant melanoma. The unusual reaction in these patients suggested possible immunological factors involved in the regression. In order to approach this problem, their sera were injected into mice with Harding-Passey melanoma. No effect of human serum upon tumor growth in the mice was discerned. It is believed that the failure of the serum from these two patients with regression of proved melanoma metastases to influence the progression of the melanoma in the mice was probably due to too wide variance in tumor types. Further immunological investigations of melanoma regression are suggested.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Hail, Great Physician

This month we celebrate an obstetrical event of nineteen hundred and sixty years ago that was unique in medical annals as well as in the recordings of this world's civilization.

Despite the claim that followed this accouchement, from the standpoint of present day care and technique, all the rules of "good obstetrics" were broken. As far as can be determined, the primiparous woman received no antepartum care, no vitamins, calcium, or hematinics, no routine checkups. Even worse, she was subjected during the late antepartum period to an arduous journey on foot or on the back of a beast of burden merely to come to town to register in accordance with instructions of the country's ruler.

Having arrived in the bustling town of Bethlehem, this mother-to-be found not only no hospital accommodations available but even no room at the local hostelry. She was forced to undergo labor and delivery in a stable with its attendant variety of microscopic infectious organisms, from which she miraculously escaped. She was attended in delivery only by her husband, totally inexperienced in this sort of thing, no obstetrician or even a midwife being on hand.

This birth, though little noted at the time, marked a turning point in history and a change in men's relationship to each other and between men and their deity. The baby born grew into the man Jesus Christ, who, among His many titles, is known as the Great Healer and the Great Physician because of the cure of diseases of the mind and body He wrought through faith. He lived a life of humility, setting a pattern of perfection for all of His followers to attempt to attain. The poor and the helpless were to Him of particular concern.

In addition to His humility, self sacrifice, and sympathetic understanding, which traits we as physicians might well emulate, He gave to mankind many statements of principles applicable to the traditional attitude which we hold, or should hold, toward the unfortunate, for "The poor always ye have with you," and "Judge not according to the appearance."

We can well advance our public relations by continued service in charity for as He said, "Out of the abundance of the heart, the mouth speaketh." The recompense for such service lies in the inner satisfaction that comes from serving the Son of God—"Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."

Since He lived, suffered, and died that men might have a more meaningful existence and a promise of everlasting life, it is fitting that we hail the day of His birth now, as then—*"Glory to God in the highest and on earth peace, good will toward men!"*

Leo M. Wachtel

THE JOURNAL
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The Doctors' Image

FRANK G. SLAUGHTER, M.D.

In recent years the bourgeoning science of public relations has developed a new yardstick by which to measure the success or failure of those who provide a service to mankind in general, as does the medical profession. This yardstick is an evaluation of the "public image," the picture of a specific group existing in the minds of the people as a whole. Techniques of evaluation have been developed which are startlingly accurate; from the public image the reactions of the people, as far as a particular group or profession is concerned, can be predicted with considerable success. Business is making increasing use of this valuable tool; as we approach a new year, and a new federal administration, it is well to consider the image of medicine in general and the doctor in particular that exists in the public mind.

The perfectly human tendency to blame the physician if his endeavours are not successful was epitomized by Job when, from the depths of his misery, he cried out, "But ye are forgers of lies, ye are all physicians of no value." Robert Louis Stevenson was kinder; he said, "Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a thousand embarrassments; and what are more important, Herculean cheerfulness and courage."

The image of a particular doctor in the mind of a patient no doubt varies with the course of an illness, but by and large the image of the profession in general held by large numbers of people is a reflection of many factors and not so easily changeable. A hundred years ago the picture of a physician as a warm friend and a bulwark in time of trouble was a tribute to his self sacrifice and his dedication to his profession. Today, unfortunately, that image is much less confidence-inspiring. More important, unless we, as individual physicians, take more thought about the reasons why this deterioration has occurred, and some steps to reverse what may already have become a disastrous trend, it may well be too late. Already, and not simply in the courts, far too many people, like Job, are accusing doctors of being "forgers of lies . . . physicians of no value"—and with considerable reason.

The sharp change that has taken place in the public image of the medical profession is a fairly recent occurrence. As recently as the end of World War II, the doctor was regarded by the public with the highest esteem. The record of the medical profession's accomplishments in saving lives was of the very highest order, its dedication unquestioned. Where then have we failed in the short space of 15 years?

The answer to this vitally important question must be sought inside the physician's own image of himself, but only if he can be objective and ruthlessly self-critical. Thirty-four years ago, when this writer entered medical school, the first year curriculum included a truly inspiring series of seminars on medical history and the background of medical idealism; today few schools even bother with such subjects at all. If the "Generosity . . . such as is possible to those who practice an art" described by Stevenson is not granted to "those who drive a trade," is it unreasonable to say that the marked decline in that generosity which today characterizes much of medical practice indicates that what started out as the most honored of professions may now largely have degenerated into a trade? And having degenerated, does the medical profession have a right to expect the people or the government to consider it as anything more?

It is easy to blame our leadership for our failure to maintain the public image of the dedicated physician of past generations and for the fact that today many people regard doctors as members of a closely restricted trade union battling desperately against social progress. But seeking thus to find a scapegoat is unrealistic for our leadership must always be a product of our own individual dedication. If it is poor, this can only be because doctors as a whole do not feel strongly enough about their idealistic heritage to remedy the lack. But until it is remedied, we will be constantly on the defensive when we should be providing leadership. If a dangerous trend, a sharp loss of public esteem, is to be reversed, the people must realize the traditional concern of physicians for their welfare in keeping with the great idealistic heritage that is ours.

The public image of the medical profession is a composite of many private images. When each doctor concerns himself with the private image he inspires in his patients, the rest will take care of itself. It is still not too late for leadership in solving the difficult social and economic problems of providing medical care for everyone within his means to come from those best qualified to give it, the doctors themselves.

Editor's Note: The Journal is honored to have for the eighth consecutive year a December guest editorial from the pen of Dr. Frank G. Slaughter of Jacksonville, Florida's distinguished physician-author.

Diagnosis of Early Rheumatoid Arthritis

When confronted by a patient with acute arthritis of short duration, a physician must search among at least 50 diseases and syndromes for an accurate diagnosis. Early rheumatoid arthritis is typified by "flare-ups" and remissions, usually with no characteristic x-ray changes, telltale nodules, or deformities. At this stage, the clinical picture may simulate that of systemic lupus erythematosus, early scleroderma, allergic angiitis, serum sickness with polyarthritis, acute gouty arthritis, and such rheumatoid variants as arthritis with psoriasis, ankylosing spondylitis, or Reiter's syndrome. Of aid in this diagnostic dilemma is the American Rheumatism Association's Primer of Rheumatic Diseases,* which contains simplified criteria for diagnosis of rheumatoid arthritis, analogous to the Jones criteria for rheumatic fever. "Nutshell" summaries of other diseases which may mimic rheumatoid arthritis are provided in this carefully prepared booklet. The diagnosis of rheumatoid arthritis is subdivided into categories of Possible, Probable, Definite and Classical. For each of these there is a minimal list of positive findings and for all, a list of exclusions. Early symmetrical involvement of the wrists and metacarpopha-

*J. A. M. A. 171:1205-1220, 1345-1356, 1680-1691, 1959. Available as a reprint from the National Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 18, N. Y.

langeal joints together with severe joint stiffness after inactivity is an extremely suspicious finding favoring rheumatoid arthritis. Relative specificity can be ascribed to (1) rheumatoid nodules or synovia revealing on histologic study typical central areas of fibrinoid change surrounded by palisaded fibroblasts (also found in rheumatic fever) and (2) presence of "rheumatoid factor" in serum. This serum factor is one or several proteins which resemble the macroglobulin of the Wassermann, heterophile and blood group antibody category, and may be detected by its interaction with human gamma globulin coated on one or another "particle" such as bentonite, latex or sheep cells. The tests are positive in 70 to 95 per cent of patients with rheumatoid arthritis, but the specificity is variable from one disease to another. Patients with osteoarthritis and milder rheumatic disorders give 1 to 5 per cent positive serologic reactions by these tests. There are, however, reports of a high frequency of positive reactions in patients with other "collagen diseases," as well as syphilis, sarcoidosis, essential hypertension, peptic ulcers and liver disease. Despite intensive characterization of the rheumatoid factor, its relationship to the cause of rheumatoid arthritis still is unknown.

Before starting treatment, what does one tell the patient subsequent to a thorough medical examination? With neuropsychiatric problems often a paramount feature of their illness, these patients seem to require especially tactful handling. Illustrated pamphlets, available through the National Arthritis and Rheumatism Foundation, are time savers in patient indoctrination.** In instances of Possible or Probable rheumatoid arthritis, the patient should be told frankly that a definite diagnosis frequently cannot be made at one point in time and that follow-up studies are necessary. "Arthritis of undetermined etiology" is suggested for use on hospital records and other forms. In some patients, the current findings may best fit the diagnosis of nonarticular rheumatism, fibrositis, or palindromic rheumatism. Although later a suspected rheumatoid arthritis becomes apparent, the milder interim diagnosis serves to prepare the patient for a treatment program. As the result of ever increasing information in the field of rheumatic diseases, early diagnosis is becoming for the physician and the patient a more rewarding process.

David S. Howell, M.D.
Director Arthritis Section
University of Miami School of Medicine

**Helpful booklets available from the Florida Chapter of the National Arthritis and Rheumatism Foundation, 1206 Huntington Building, Miami, include Home Care in Arthritis, Diet and Your Arthritis, Osteoarthritis, Rheumatoid Arthritis About Gout, and Strike Back at Arthritis.

The Showcase

What *should* an editorial page contain? Obviously, this is a question which calls for conclusion on the part of the witness—for prejudice and for partiality.

The editorial page is the showcase of the establishment. It is the center, the vital point, of the publication, and herein—as in any showcase—one carefully and tastefully exhibits one, two, or three—never very many—of the most valuable, attractive gems to which he has access. Here the observer has the right to expect to find displayed the really fine jewels that set the standard of quality of the organization—the true treasures of the house—not the brightly burnished baubles of superficiality. Simply by careful perusal of this showcase—or this page—one should be able to infer the scope, the depth, the aims and the significance of the publication itself.

Here on a deep, inspiring velvet background, it is your job and mine to arrange in succession ever inviting displays of the cool, solitary pearls of medical wisdom—the clear, sparkling diamonds of discovery—the mysterious, philosophic and historic jade — the exciting and provocative emeralds of investigation—the disturbing, restless rubies of romance—and the fiery opals of challenge and controversy. These, and all the other gems in our collection, must be arrayed and arranged in such a fashion as to catch the eye, stimulate the spirit and engage the mind. Cer-

Presented at the Third Regional State Medical Editors Conference, Lexington, Ky., Oct. 15, 1960.

tainly here belong the concise and condensed nuggets of scientific medical wisdom recapitulated in one short paragraph; and certainly here, also, belongs the solemn but skillful reiteration of the basic ideals and tenets of our great profession, coupled with an emphasis of its glorious heritage and its awesome obligations and responsibilities—a periodic statement of principles—which should not be necessary, but which *is*. In this realm, only, should the editorial page assume the form of a pulpit.

Elsewhere, it should shun the didactic and the oracular, concerning itself instead with the novel, the tantalizing, the provocative and stimulating questions of medical practice and medical philosophy. It should explore the unknown. It should raise questions and new concepts. It should at times irritate, tantalize, and even torment us, until we are reluctantly aroused from the smugly self-sufficient stupor into which we may have lapsed. It should, of course, provoke discussion—provoke comment—provoke criticism. Like a good instructor, it should lead the discussion, keeping the magazine and its readers on their intellectual toes. Furthermore, in this manner it should seek from its audience answers to the complex problems of our ever changing times.

In our Journal, we have elected to publish each month at least two editorials: one always on a strictly professional and scientific aspect of Medicine—concise, comprehensive and authoritative—contributed by an outstanding authority in the special field to which the tiny essay relates; and a second general editorial written by a member of the Editorial Board, or some person selected by him, and dealing with medical philosophy, medical history, or any of the phases of the socio-economic chaos that engulfs our medical world today. In addition, editorials are attempted on any timely subject that has a sense of urgency; and periodic short essays on the various facets of organized Medicine, with its responsibilities and obligations, are interspersed throughout the year. Still, our editorial page falls far short of the glamorous goal which I have outlined earlier, and this is why, since I am a very indifferent jeweler, I read *your* pages much more often than my own.

One reason, I suppose, that all of our pages miss the mark by considerably more than we would like, is the fact that none of us—with rare exception—is a full time professional in this field. This brings up one interesting last point, after which I have done; that is, two different concepts of the editorial page: one in which it represents the continuing personal link with the person of the editor himself—his individuality and his personality—and in which instance the entire magazine is in a sense the work of, and the expression of, an individual. Here it of course follows that the magazine and its editorial page will be excellent if the editor himself is excellent; poor if he is of mediocre ability. This is perhaps an ideal format if one has a William Allen White—a *Doctor* William Allen White, in this case—who can act as a full time, on-the-spot editor, who can instill and breathe into each issue of the magazine his vital, dynamic, inspiring personality.

Unless you have such a person available to write each editorial page and in it to editorialize the remaining contents of the journal, interpreting and directing their consumption by the reader—unless you have such an individual, I say, you must, perforce, accept the more practical—if less perfect—solution. Many journals have, I believe, found that an editorial board of three or more members *can* achieve continuity and produce editorial pages and editorial policy of a satisfactory and constant nature, while continuing to practice Medicine. We can, in our limited fashions, then, individually engender the impetus necessary to carry us through three or four deadlines annually with reasonable efficiency, if not with enthusiasm and gusto; and we can do the job in an acceptable—if not an exemplary—manner.

So, in conclusion, it is, you see, really very simple. Each editorial page should contain only this: just a few precious and tantalizing drops of the distillate of all the imagination—ideals—dreams and dedication—humor and pathos—in short, of all the wit and all the wisdom of the world!

J.W.A.

Florida Diabetes Association Holds Annual Meeting

The eighth annual meeting of the Florida Diabetes Association was held on October 27-28, 1960, in the Balmoral Hotel at Miami Beach. Registration for the event was 76.

Dr. Morris B. Seltzer of Daytona Beach, chosen president-elect at the 1959 meeting, assumed the office of president, and Dr. Theodore F. Hahn Jr. of DeLand became president-elect.

Dr. George F. Schmitt Jr. of Miami was re-elected secretary-treasurer. The Board of Governors for 1961 includes Dr. Hahn; Dr. Grover C. Collins of Palatka, immediate past president; Dr. William C. Thomas Jr. of Gainesville; Dr. Joseph J. Lowenthal of Jacksonville, and Dr. Kenneth Phillips of Miami.

The scientific program was presented by guest speakers and member speakers. Guest speakers were Dr. George Hamwi, Professor of Medicine and Chief of the Division of Endocrinology and Metabolism, Ohio State University College of Medicine, Columbus; Dr. Alexander Marble, Physician, New England Deaconess Hospital, and Assistant Clinical Professor of Medicine, Harvard Medical School, Boston; and Dr. Roger H. Unger, Assistant Professor of Internal Medicine, University of Texas Southwestern Medical School, Dallas. Member speakers were Dr. A. Gorman Hills, Professor of Medicine, and Dr. George F. Schmitt Jr., Assistant Clinical Professor of Pharmacology, University of Miami School of Medicine, and Dr. Joseph C. Shipp, Assistant Professor of Medicine, University of Florida College of Medicine.

The 1960 annual award of $100 for the best paper on the subject of diabetes by a resident or intern in the state was presented to Drs. Edith Joan Bradley and William Kho of the Duval Medical Center in Jacksonville.



Dr. and Mrs. Peek

Dr. and Mrs. Eugene G. Peek Sr. Celebrate Golden Wedding

On the occasion of their golden wedding anniversary, Dr. and Mrs. Eugene G. Peek Sr. of Ocala were tendered a reception on Sept. 28, 1960, at the home of their son and daughter-in-law, Dr. and Mrs. Eugene G. Peek Jr. Their daughter, Mrs. James M. Smith Jr., was among those receiving with them, and all six of their grandsons were in attendance. Assisting in various capacities at the reception were 42 of their friends.

Dr. Peek is a distinguished past president of the Florida Medical Association, having held that office in 1943, and has also served both his community and his state with great distinction. The Journal takes pleasure in saluting this native Floridian and his wife who for half a century have walked hand in hand down the corridor of time and congratulates them on the happy occasion that enabled their host of friends to honor them and wish them well.

The Third Annual Conference For County Medical Society Presidents And Secretaries

The Third Annual Conference for County Medical Society Presidents and Secretaries sponsored by the Florida Medical Association will be held Saturday afternoon and Sunday morning, January 14-15, 1961, according to announcement by Dr. Leo M. Wachtel of Jacksonville, President of the Association. The Conference is scheduled for the Hotel Robert Meyer in Jacksonville. The program has been planned particularly for the presidents and secretaries who will assume their offices the first of the year; however, it is hoped that other officers of the county medical societies will also attend.

Saturday afternoon will be devoted to the current problems and programs of the American Medical Association, followed by a presentation

dealing with the responsibilities of county medical societies. This will be followed by four panel presentations covering major activities of three Florida Medical Association councils: legislative programs and indigent medical care; Florida Medical Association Investment Trust and insurance programs; fee schedules, Blue Shield and commercial health insurance, and the Florida Medical Foundation. A reception and dinner for those in attendance will follow. The Sunday morning program will be opened with a presentation of the responsibilities of county medical society officers, and the remainder of the morning will be devoted to discussion by the county medical society officers of their programs and problems. Following each panel presentation, there will be adequate time for questions and answers.

This program was developed by the Executive Committee after carefully reviewing the comments of those in attendance at the two previous conferences, and is designed primarily to present the over-all programs and policies of the American Medical Association and the Florida Medical Association to the presidents and other officers of the component county medical societies, to assist them in coordinating and carrying out these programs at the county level.

University of Florida College of Medicine 1961 Winter-Spring Seminar Schedule

The Division of Postgraduate Education of the University of Florida College of Medicine will present four Seminars this season, all at the College of Medicine in Gainesville. Conferences on Pediatrics, Obstetrics and Gynecology, and Surgery are scheduled for next month and a Seminar in Neurology in March. The physicians of Florida and South Georgia have been invited to attend these Seminars, which have the approval of the Florida Medical Association and the Florida State Board of Health. Distinguished guest lecturers and departmental staff members of the College of Medicine will serve on the faculty of each Seminar.

On January 12 to 14, a Seminar in Pediatrics will be presented by the Department of Pediatrics, Dr. Richard T. Smith, Chairman. Visiting faculty members will be Dr. Albert Dorfman, Professor of Pediatrics, University of Chicago School of Medicine, and Dr. Nathan J. Smith, Professor and Chairman, Department of Pediatrics, University of Wisconsin Medical School.

A Seminar in Obstetrics and Gynecology will follow on January 19 and 20 under the auspices of the Department of Obstetrics and Gynecology, Dr. Harry Prystowsky, Chairman. The guest lecturers will be Dr. R. W. TeLinde, Professor and Chairman (Emeritus), Department of Gynecology, The Johns Hopkins Hospital, Baltimore, and Dr. B. F. Carter, Professor and Chairman, Department of Obstetrics and Gynecology, Duke University Medical Center, Durham, N. C.

The third course in January will be a Seminar in Surgery from January 26 to 28, presented under the direction of the Department of Surgery, Dr. Edward R. Woodward, Chairman. Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School, and Dr. Lester R. Dragstedt, Research Professor of Surgery, University of Florida College of Medicine, will lecture.

Scheduled for March 16 to 18 is a Seminar in Neurology, presented by the Department of Medicine, Division of Neurology, Dr. Richard P. Schmidt, Chairman. Dr. Augustus S. Rose, Professor of Medicine and Neurology, University of California Medical Center, Los Angeles, will be the guest speaker.

The Florida Midwinter Seminar Of Ophthalmology and Otolaryngology Miami Beach, Jan. 29-Feb. 4, 1961

The Fifteenth Annual Florida Midwinter Seminar of Ophthalmology and Otolaryngology will convene in Miami Beach on January 29 and continue through February 4, 1961. All meetings will be held at the Americana Hotel from 8:30 a.m. to 1:30 p.m. This schedule allows ample time for the enjoyment of the vacation facilities of the area. The Seminar is presented in cooperation with the College of Medicine of the University of Florida and the University of Miami School of Medicine.

The lectures on Ophthalmology will be given on January 30 and 31 and February 1. The lecturers will be Drs. Walter S. Atkinson of Watertown, N. Y., William Havener of Columbus, Ohio,

Charles E. Iliff of Baltimore, Irving Leopold of Philadelphia, and Alfred Maumenee of Baltimore.

On February 2, 3 and 4, the lectures on Otolaryngology are scheduled. Drs. John F. Daly of New York City, David D. De Weese of Portland, Ore., Paul Holinger of Chicago, and Harold Schuknecht of Detroit will present these lectures.

All registrants and their wives will be guests at a cocktail party at the Americana on Wednesday, February 1, at 6:30 p.m. That same evening at 8 p.m. there will be the usual informal dinner.

This popular winter graduate course is sponsored in the Division of Ophthalmology by Drs. Shaler Richardson and Charles W. Boyd of Jacksonville, Joseph W. Taylor Jr. of Tampa, and Kenneth S. Whitmer and Edward Norton of Miami; and in the Division of Otolaryngology by Walter T. Hotchkiss of Miami Beach, G. Dekle Taylor of Jacksonville, Carl S. McLemore of Orlando, James R. Chandler Jr. of Miami, Charles C. Grace of St. Augustine, and Thomas M. Edwards of Tampa.

Orthopaedic Surgeons Hold Annual Meeting January 8-13, Miami Beach

The Twenty-Eighth Annual Meeting of the American Academy of Orthopaedic Surgeons will be held at the Americana Hotel in Miami Beach on January 8-13, 1961. Registration and Exhibits will open on Sunday, January 8. The Instructional Courses will be offered on Monday, Tuesday, Wednesday and Thursday mornings. The Scientific Program and the Audio-Visual Program are scheduled to begin on Sunday afternoon and continue through Friday afternoon, January 13, except for Wednesday afternoon, which will be left free for all to enjoy their favorite diversion. The Executive Sessions will be held on Monday afternoon, Thursday morning, and Friday afternoon.

The ever popular Instructional Course dinner is scheduled for Tuesday evening, and Wednesday evening has been reserved for alumni functions. The Annual Banquet on Thursday night will highlight the social activities.

The Florida meeting should be a particularly memorable occasion. The elaborate program featuring excellent original papers, 115 Instructional Courses of which 44 are new, 52 Scientific Exhibits and a number of new motion pictures will no doubt have wide appeal, especially when coupled with the midwinter attractions of the tropical Miami area. The Research Society program and that of the American Society for Surgery of the Hand, which meets there on January 6 and 7, will provide additional interest.

Florida physicians serving as regular members of the faculty for the Instructional Courses or as guest instructors include Drs. Rush K. Acton, Henry L. Dean, N. Joel Ehrenkranz, Claude D. Holmes Jr., and David S. Howell, Miami; Robert P. Keiser, Coral Gables; and George T. F. Rahilly, Fort Lauderdale. Among those presenting scientific exhibits are Dr. Lee J. Cordrey, Tampa; Drs. William F. Enneking and Nicholas R. Greville of the University of Florida College of Medicine, Gainesville; Dr. Irving E. Fixel of Memorial Hospital, Hollywood; Dr. William S. Hatt, Sarasota; Drs. David S. Howell, Harvey Brown and Augusto Sarmiento of the University of Miami School of Medicine and Jackson Memorial Hospital, Miami; Dr. Philip O. Lichtblau, West Palm Beach; and Drs. Newton C. McCollough and Donald W. Grimes of the Florida Crippled Children's Commission, Orlando, Ross Allen of the Ross Allen Reptile Institute, Silver Springs, and Joseph F. Gennaro Jr. of the National Institutes of Health, Gainesville.

OTHERS ARE SAYING

Editorial Comment

Heritage and Obligation. Under this title the *Westchester Medical Bulletin** comments editorially on a topic which in our opinion cannot be too often and too emphatically stressed. Especially is this true when the comment is made with such elegance that it clothes an old truth in an attractive new dress. Says the *Bulletin:*

> One of the attributes which most distinguishes man from the rest of the animal kingdom is his ability to communicate not only with his contemporaries, but, through the vast stores of his creations, with the future generations, long after he has passed on. It is this priceless distillate of tragedy and good fortune, anguish and inspiration, which, crystallized, becomes our heritage; and there is no part of life which has not seen the brilliance of the past reflected in itself. Nor can we contemplate our origin without some pangs of pride in this rich

treasury of art and science, philosophy and religion, custom and tradition.

But this privilege of heritage implies an obligation to the future that it will not be marred by the present. For, no matter what our wish, we are indeed participants in its creation.

Our nation is at a crossroads of indecision in which the principle of individual responsibility and freedom of choice is challenged. There are those who would sacrifice it on the altar of expediency and would replace this precious birthright with a paternalistic government control and provision from the cradle to the grave. Our legislative friends, imbued with an instinct for sensing what is popular, seem willing to abandon sound principles of economy and individual rights for the proposition that "everybody loves Santa Claus." The great illusion that we can provide something for nothing appears sufficiently attractive on the surface to be flounced about temptingly by the politicians.

A case in point is the recent plethora of bills being introduced in Congress which are, in fact, variations of the Forand Bill. All are aimed at the provision for hospitalization to the elderly beneficiaries of social security; and some include surgical and diagnostic services as well. Fundamentally, they are similar, and in spite of all protestations to the contrary, their ultimate objective is total socialization of medicine.

But to be merely cognizant of these threats is not enough to stem the course ahead. We must abandon the philosophy that favors a status quo, and is antagonistic to all which threatens it. In a world of continuous change, no policy can be expected to remain acceptable indefinitely. It is useless to prove statistically that there is no need for change, when, in fact, the momentum of public opinion is already in the direction of change! There is an anguished cry for new ideas. It is a mixed cry. It is a cry of despair and a cry of warning, which, like the voice in the wilderness, unheeded, leads to calamity!

If the heritage we prize so dearly is to be preserved and enhanced, we must move with the tide of evolution, discarding the useless, and protecting the valued. If our way is to survive, we must rid ourselves of our indifference, our apathy, and our defeatism. Finally, we must destroy that malicious habit, so long indulged in that it has become a trade mark of our pattern of action, namely, the habit of opposition without proposition.

We would be the last to condone "opposition," merely for its own sake in most instances. Yet it is a tried and valuable military tenet that attack is the best defense weapon. For much of its recent history organized medicine and individual physicians have been forced into a defensive position by the press, by legislative bodies, and by the courts of law. We concede that "proposition" should be included among the weapons of defense to continue the military analogy, but "proposition" is frequently a tool of great usefulness at the diplomatic conference table if the invasion is halted or the ambush prevented. The profession of medicine has survived for a long time probably for the reason that though it has lost many battles it has generally won the wars.

*28:21 (Apr.) 1960.

New York State J. Med.
June 1960.

PHYSICIAN'S HOBBIES

Ham Operators

Ham radio operating brings no financial return for the cost of the equipment or for the years of study and of devoted duty to monitoring the station. The reward is in the many errands of mercy the dedicated operator repeatedly undertakes, in the many friends made all over the world, in the awareness of the importance the operator plays in the national defense, and in the soul-satisfying knowledge of a job well done.

Ham operating may be an expensive hobby in time as well as in money. A small setup will cost between $200 and $300, and from there it can increase ad infinitum to as much as $10,000. About eight months are required to obtain a novice license and about a year to get a general license. There is no cost for the license; however, it has to be renewed every five years and periodically the station is checked by agents of the Federal Communications Commission.

A Ham Operator is obligated to monitor his set regularly and, of course, this obligation can become a little difficult for the busy medical practitioner who, while transmitting, often has to say, "QRX (wait a minute) while I answer this landline." when he is interrupted by a telephone call from a patient.

Operators have a jargon all their own. Their station, whether a basic rig in a shack or the most expensive in a mansion, is still called the "Ham Shack." They do not broadcast; they "transmit." Aside from the standard code, they have some interesting initials of their own, like "QSO" (conversation), "QRX" (wait a minute), and "QRM" (static). So an "Eyeball QSO" is a tête-à-tête conversation, a "Landline QSO" is a telephone conversation, and a "Phone Patch QSO" is a telephone hooked up to a radio. The operator is an "OM" (old man) unless the operator is an unmarried girl, and then she is a "YL" (young lady). If she is married, then she is an "XYL" (ex-young lady), and if the OM's son is an operator, too, he is a "JO" (junior operator). Other children in the family are referred to as "Harmonics."

Senior "OM" in the Dade County Medical Association is Dr. John V. Handwerker Jr. who has been enjoying the hobby for 22 years. His call letters are W4-GGH. While in college and

medical school, Dr. Handwerker augmented his income by working in commercial radio. He has tried on several occasions to compile a list of MD Hams throughout the United States, and, at present, has a list of more than 50 physicians, their call letters and "handles."

Dr. Arthur F. Schiff has been a Ham for 12 years. He operated station KA2-AS (Arthur Schiff) for FECOM in Japan while stationed there in the Army from 1951 to 1953. His present call letters are W4-UYJ (United Yokohama Japan).

Dr. Harvey L. Jorgenson has been a Ham for 15 years. His call letters were W9-EOQ (Easy Old Quack) when he was in Wisconsin, and for the past nine years in Miami, he has been transmitting from W4-UHM (Uncle Harvey's Misery). Dr. Jorgenson likes to talk about his hobby, of the friends he has made all over the country and throughout the world, and of the many who have dropped in on him when they were in the Miami area for an "Eyeball QSO" (face-to-face conversation) and sometimes a "Highball QSO."

The fourth Ham Operator in the Dade County Medical Association is Dr. Eduardo F. Pena who has been a Ham for six years with the call letters W4-DVW. He talks with his family in Madrid twice a week and has constant correspondence with operators in Tokyo, New Zealand and Madrid, all physicians. Dr. Pena received a commendation from the American Radio Relay League in 1959 for saving a boy's life on an island in the Pacific off the west coast of Columbia, San Andres. The boy was seriously ill from dehydration and starvation, secondary to shegellosis dysentery. Dr. Pena ordered intravenous fluids, electrolytes and other medication, and stayed at his radio until he was able to get a doctor to fly out from Columbia to care for the patient. He has done many other errands of mercy, as have all these men, who, as physicians, probably have greater motivation along these lines and are better able to expedite the necessary lifesaving measures.

Wilfred Lansman, M.D.

Note: This is the fifth in a series of discussions of various hobbies being enjoyed by physicians in Florida. These articles are published in the hope that those physicians who do not have a hobby might be encouraged to begin one, and for those who do have a hobby, these remarks may be a source of interest. The Committee on Scientific Work would like to know about your hobby for possible display at the next Annual Meeting. The blank published in this issue of The Journal is for your convenience.

SHARE YOUR HOBBY

My hobby is _____

_____

_____

_____

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_____

_____

Please reserve space for me to display it at the Annual Meeting in Miami Beach.

Signed _____

Mail to:

Wilfred Lansman, M.D., Chairman
Display Arrangements for Hobby Exhibits
P. O. Box 2411, Jacksonville

BLUE SHIELD

New Blue Shield Contract

As announced in the October issue of Briefs, a new Blue Shield contract has been developed following months of extensive study and cooperative efforts by the Florida Medical Association Fee Schedule Committee and Committee of Seventeen, and the Blue Shield New Contracts Committee. Offering this new contract to the public was approved by the Association's House of Delegates at its last meeting, and was made available by Blue Shield of Florida, Inc., for the first time in November 1960.

This new contract, to be known as Type "K," is essentially identical, benefit-wise, to the low option Blue Shield contract available to employees of the federal government and employs the same schedule of benefits. Maximum fees are determined on a relative value basis, utilizing a conversion factor which is designed to provide full service benefits to subscribers with annual family incomes of $4,000 and $3,000 for those having one person contracts.

Detailed information, including a Schedule of Benefits, has been sent to each participating physician by Blue Shield. It is essential that physicians and their office personnel familiarize themselves with the provisions of this new contract. A study of this material will point out the advantages of the Type "K" coverage to the subscriber and to the physician over that of the older Type "J," with its numerous shortcomings and inequities. First and foremost is the basing of fees on a relative value system, which, in view of the higher income levels, makes possible a schedule of benefits more nearly in line with customary charges for professional services. Through its broader scope the 'K" contract provides coverage above and beyond that available through the "J." Among the benefits provided are: in-hospital surgical services, plus minor surgery in the hospital, home or office; maternity after 270 days of continuous coverage under Blue Cross-Blue Shield; inpatient or outpatient x-ray therapy for specific proved malignant disease; in-hospital diagnostic x-ray when in connection with a condition which requires hospitalization, or wherever rendered if within 72 hours of an accident; in-hospital pathology and physical therapy; and electroshock therapy in or out of the hospital up to a maximum dollar amount per contract year.

It is believed that Blue Shield has been able to rate this new contract low enough to make it appealing to the public. It will cost less than the Type "A" which is designed for a family income level of $5000. It in hoped that the price is low enough, when considered in the light of its broader scope, higher schedule of benefits and greater coverage, to encourage existing groups and direct pay subscribers to replace their present Type "J" Blue Shield coverage with the new and better "K."

This is indeed a progressive step for the Doctors' Plan, and places one more hurdle in the path of social planners. It merits the enthusiastic and aggressive support of the medical profession, without which it has but little chance for success.

STATE NEWS ITEMS

Dr. Augustus E. Anderson Jr. of Jacksonville presented a paper entitled "Diffuse Pulmonary Infiltrations" as part of the symposium on the "Role of Steroid Therapy in Chest Diseases" at the Interim Session of the American College of Chest Physicians held November 26-27 at Washington, D. C.

Dr. James N. Patterson of Tampa has been in Indianapolis, Ind., where he administered examinations of the American Board of Pathology at the University of Indiana School of Medicine.

Dr. George T. F. Rahilly of Fort Lauderdale has been visiting medical facilities in the Yucatan Peninsula and in South America.

Dr. M. Jay Flipse of Miami served as co-chairman of the Scientific Session of the Interim Session of the American College of Chest Physicians held in Washington, D. C., November 26-27. Dr. Flipse is president of the College.

Dr. Milton P. Caster of Fort Lauderdale was among the group of Florida physicians attending the meeting of the American College of Surgeons held in San Francisco.

The Hillsborough County Medical Association and the Pinellas County Medical Society are sponsoring the Sun Coast Medical Symposium December 3 at the Tides Hotel and Bath Club in St. Petersburg in cooperation with Lederle Laboratories. Representatives of the medical societies for the Symposium are Drs. Richard T. Farrior of Tampa and Robert A. Biles of St. Petersburg. Guest speakers will include Dr. Syndey S. Gellis of Boston; Dr. Robert B. Greenblatt of Augusta, Ga.; Dr. Garfield G. Duncan of Philadelphia; Dr. G. Gordon McHardy of New Orleans; Dr. Robert M. Miles of Memphis, and Dr. James Barrett Brown of St. Louis.

Dr. William Curtis Adams, formerly Assistant Professor of Child Health at the University of Louisville School of Medicine and Chief Pediatrician at the Louisville General Hospital, has been appointed Associate Professor of Pediatrics at the University of Miami School of Medicine and Medical Director of Variety Children's Hospital at Miami.

An unrestricted $5,000 medical research grant has been presented to Dr. Richard T. Smith of Gainesville, Chairman of the Department of Pediatrics at the University of Florida College of Medicine, by Wyeth Laboratories of Philadelphia, Pa.

Dr. Stephen P. Gyland Jr. of Jacksonville has been appointed by Governor LeRoy Collins as a member of the Board of Social Welfare in District Number 6, Duval County.

Dr. Clifford C. Snyder of Miami was one of the principal speakers at the meeting of the Florida State Veterinary Medical Association held October 10 at Jacksonville.

Dr. O. Whitmore Burtner of Miami presented a paper on "Diagnosis and Treatment of Selected Hemorrhagic Disorders" before the British Medical Association of Trinidad which met at Port of Spain on September 27.

A short course on the care of premature infants will be held at the Premature Demonstration Center, Jackson Memorial Hospital, Miami, December 15-16. It is approved by the American Academy of General Practice for 14 hours credit, Category I. Information may be obtained from the Bureau of Maternal and Child Health, Florida State Board of Health, P.O. Box 210, Jacksonville.

The Committee on Motion Pictures of the American College of Chest Physicians is interested in learning about new films on diseases of the chest, heart and/or lungs for possible presentation at the 27th annual meeting of the College in New York City, June 22-26, 1961. Pertinent information about films should be sent to Dr. Paul H. Holinger, chairman, Committee on Motion Pictures, 112 East Chestnut St., Chicago 11, Ill.

Dr. Robert B. Lawson of Coral Gables, Professor of Pediatrics at the University of Miami School of Medicine, has received a $5,000 medical research grant from Wyeth Laboratories. The grant is unrestricted and may be applied to any medical research project designated by the recipient.

Dr. Russell B. Carson of Fort Lauderdale attended the meeting of the New England Section of the American Urological Association held in Manchester, Vt., and issued an invitation for this Section's members to visit Florida and the Southeastern Section when it meets at the Diplomat Hotel in Hollywood, March 19-24, 1961.

Dr. Louis C. Skinner Jr. of Coral Gables has been elected president of the Miami Dermatological Society. Serving with Dr. Skinner will be Dr. Meyer Yanowitz of Miami as vice president, and Dr. Bert L. Peppercorn of Miami Beach as secretary-treasurer.

Dr. Russell B. Carson of Fort Lauderdale, chairman of the Professional Relations Committee of the National Association of Blue Shield Plans, attended the Professional Relations Conference in Chicago, October 10-12, at which principal speaker was Mr. Arthur S. Fleming, Secretary of Health, Education, and Welfare.

Dr. S. Carnes Harvard of Brooksville, President-Elect of the Florida Medical Association; Dr. John D. Milton of Miami; Dr. Irving M. Essrig of Tampa; Dr. John J. Cheleden of Daytona Beach, and Drs. Charles R. Sias and W. Dean Steward of Orlando were among the group of Florida physicians attending the Professional Relations Conference of the National Association

of Blue Shield Plans held in Chicago October 10-12.

Dr. James N. Patterson of Tampa has been elected Chairman of the Council of Clinical Chemistry of the American Society of Clinical Pathologists and Secretary of the Section of the Private Practice of Pathology of the College of American Pathologists. He also has been appointed a member of the Nominating Committee and a member of the Committee on Metabolic Patterns of the American Society of Clinical Pathologists.

A Seminar on Endocrinology sponsored by the Jacksonville Hospitals Educational Program and the Jacksonville Academy of Medicine has been scheduled for February 17-18 at Sellers Auditorium in Jacksonville. The Seminar is aided by a grant from the Chas. Pfizer Company. Guest participants include Dr. Grant Liddle, Vanderbilt University School of Medicine, Nashville; Dr. William Parsons, University of Virginia School of Medicine, Charlottesville; Dr. Melvin Grumbard, Columbia University College of Physicians and Surgeons, New York, and Dr. Stefan Fajans, University of Michigan Medical School, Ann Arbor.

The Annual Cardiovascular Seminar sponsored by the Northeast Florida Heart Association will be held at the Prudential Auditorium in Jacksonville January 26-28.

Dr. Hyman J. Roberts of West Palm Beach was among the invited faculty for the Postgraduate Course in Medicine offered by the University of Kansas Medical Center November 14-17. Later Dr. Roberts served as visiting physician pro tem at the Medical Center and Veterans Hospitals.

Dr. L. Roland Young of Daytona Beach attended the Tenth Anniversary Symposium on Biological, Psychological and Sociological Approaches to Current Psychiatric Problems on October 21-22 at the Illinois Neuropsychiatric Hospital at Galesburg. He also attended the Southern Medical Association meeting.

Dr. James T. Shelden of Lakeland has been elected president of the Florida West Coast Radiological Society. Dr. Richard V. Meaney of Bradenton will serve with Dr. Shelden as vice president, and Dr. Joseph C. Rush of Clearwater as secretary-treasurer.

Announcing The Twenty-Fourth Annual Meeting
of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters — Roosevelt Hotel
March 6, 7, 8, 9, 1961

GUEST SPEAKERS

Arthur S. Keats, M.D., Houston, Tex.
Anesthesiology
Robert R. Kierland, M.D., Rochester, Minn.
Dermatology
Frank B. McGlone, M.D., Denver, Colo.
Gastroenterology
Thomas T. Jones, M.D., Durham, N. C.
General Practice
John C. Ullery, M.D., Columbus, Ohio
Gynecology
Walter Lyon Bloom, M.D., Atlanta, Ga.
Internal Medicine
Herman J. Moersch, M.D., Rochester, Minn.
Internal Medicine
William A. Sodeman, M.D., Philadelphia, Pa.
Internal Medicine
Jack A. Pritchard, M.D., Dallas, Tex.
Obstetrics
Daniel Snydacker, M.D., Chicago, Ill.
Ophthalmology
Leon L. Wiltse, M.D., Long Beach, Calif.
Orthopedic Surgery
Sam E. Roberts, M.D., Kansas City, Mo.
Otolaryngology
S. E. Gould, M.D., Eloise, Mich.
Pathology
Stuart S. Stevenson, M.D., Jersey City, N. J.
Pediatrics
Harry E. Bacon, M.D., Philadelphia, Pa.
Proctology
Albert Jutras, M.D., Montreal, Quebec, Can.
Radiology
Robert J. O. Coffey, M.D., Washington, D. C.
Surgery
Harwell Wilson, M.D., Memphis, Tenn.
Surgery
Thomas E. Gibson, M.D., San Francisco, Calif.
Urology

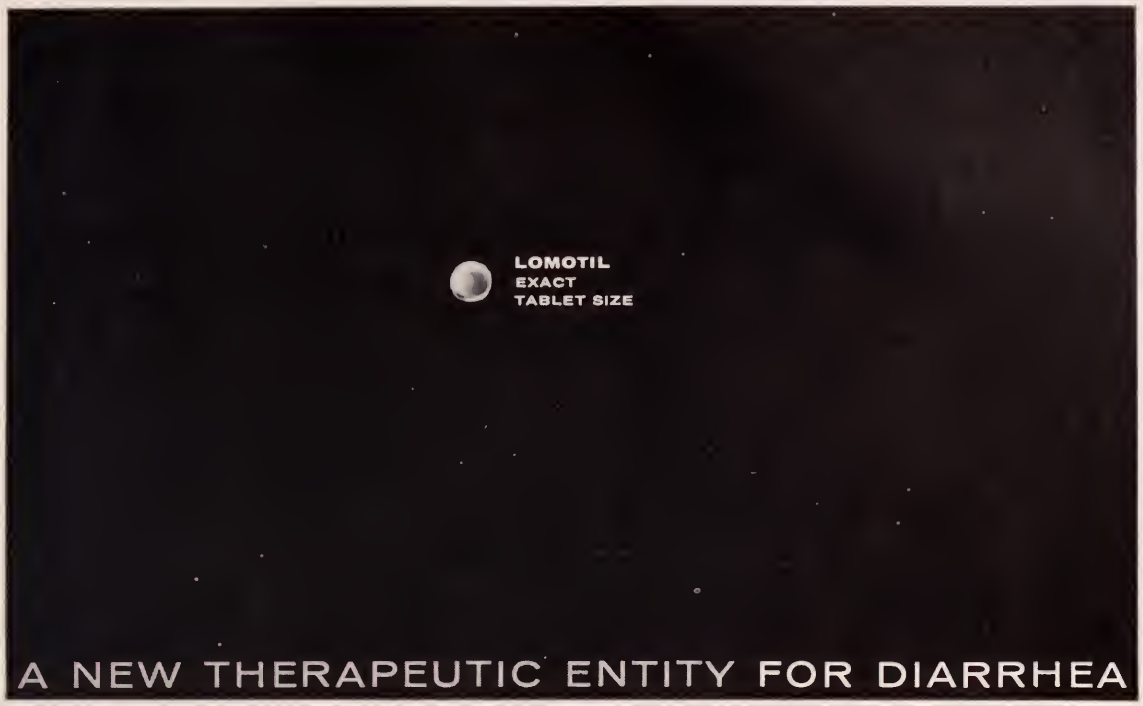
Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, scientific exhibits and technical exhibits.

(All-inclusive registration fee — $20.00)

THE CLINICAL TOUR TO THE ORIENT VISITING HAWAII, THE PHILIPPINES, HONG KONG AND JAPAN

Leaving March 10 via air and returning March 30, 1961
(Optional extensions may be arranged)

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

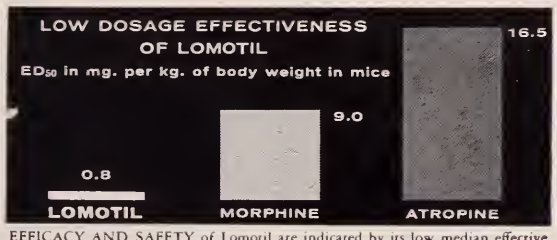
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately 1/11 the dosage of morphine and 1/20 the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control ... with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about 1/11 the dosage of morphine hydrochloride and in about 1/20 the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

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Research in the Service of Medicine



when sulfa is your plan of therapy...

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] ". . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

KYNEX is your drug of choice



once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

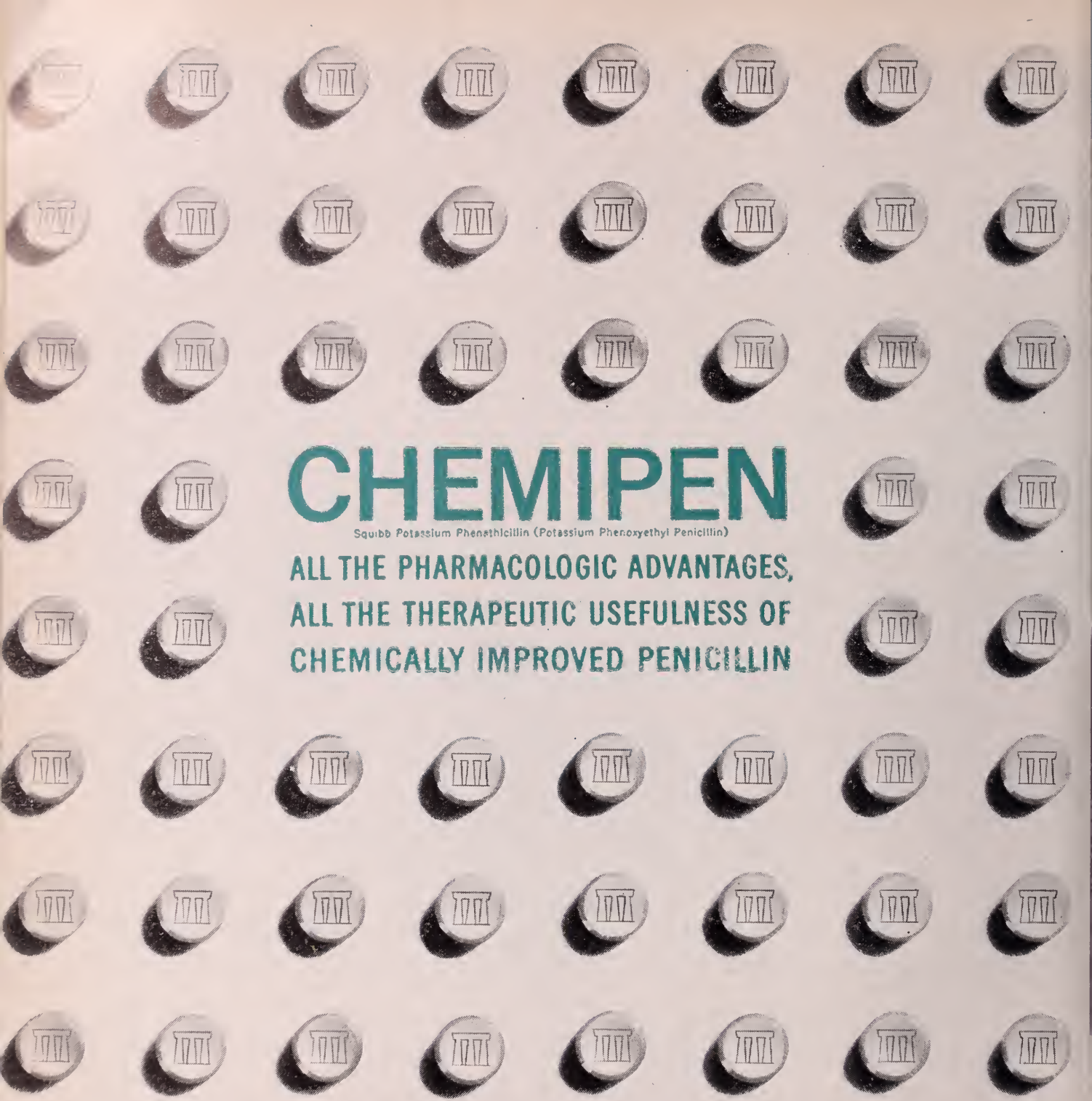
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NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

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Squibb Potassium Phenethicillin (Potassium Phenoxyethyl Penicillin)

ALL THE PHARMACOLOGIC ADVANTAGES, ALL THE THERAPEUTIC USEFULNESS OF CHEMICALLY IMPROVED PENICILLIN

Chemipen is Squibb's brand of phenethicillin potassium, the new advance in the biosynthesis of penicillin. When you prescribe Chemipen, you prescribe all the advantages of chemically improved penicillin.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 and 100 tablets. Chemipen for Syrup (cherry-mint flavored, non-alcoholic), 125 mg. per 5 cc., 60 cc. bottles. For complete information consult package insert or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N.Y. 'CHEMIPEN'® IS A SQUIBB TRADEMARK.

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Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

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in premenstrual tension only neo Bromth treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

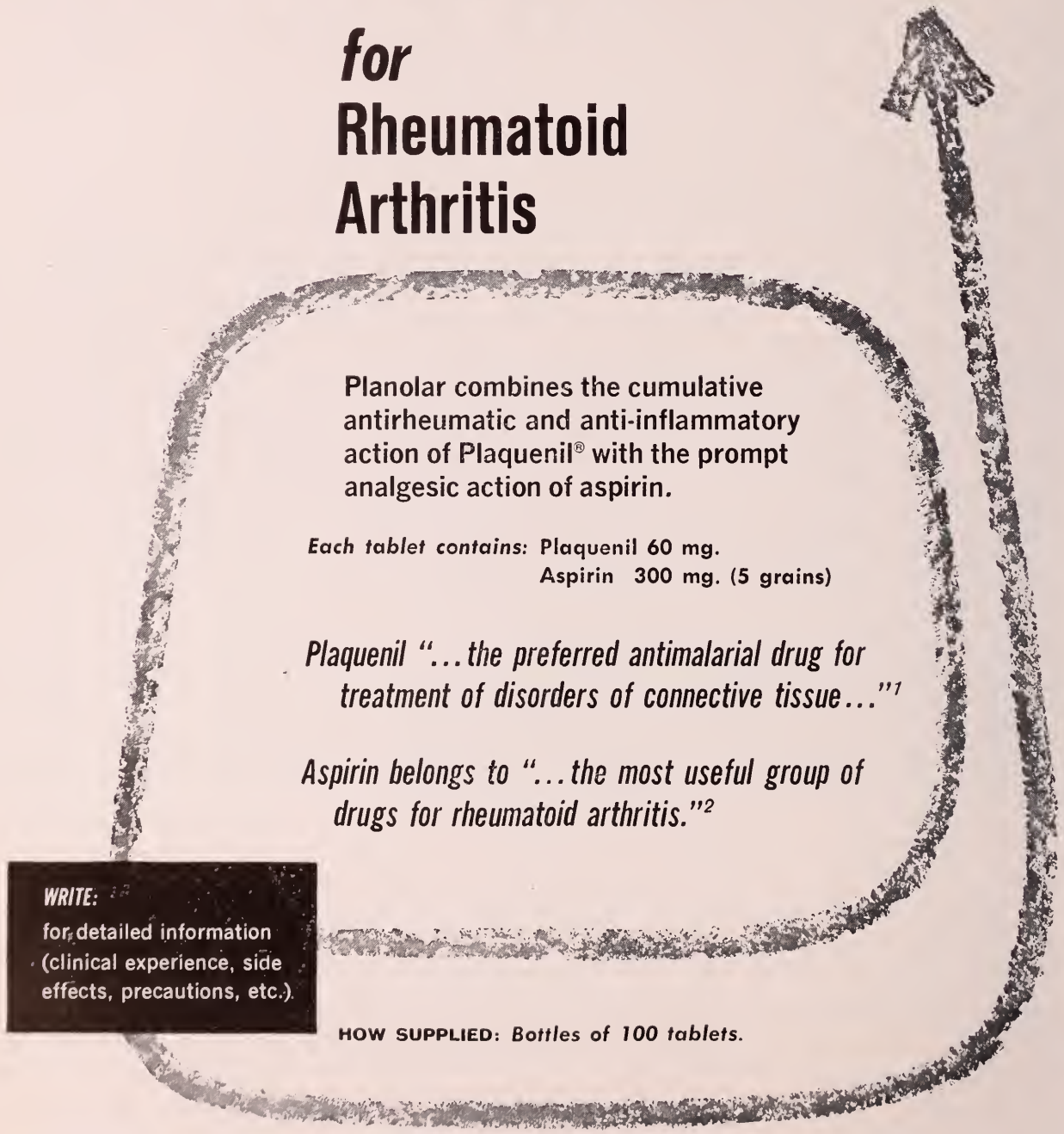
Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee

NEW *Antirheumatic Analgesic*

PLANOLAR*

for Rheumatoid Arthritis



Planolar combines the cumulative antirheumatic and anti-inflammatory action of Plaquenil® with the prompt analgesic action of aspirin.

Each tablet contains: Plaquenil 60 mg.
Aspirin 300 mg. (5 grains)

Plaquenil "...the preferred antimalarial drug for treatment of disorders of connective tissue..."[1]

Aspirin belongs to "...the most useful group of drugs for rheumatoid arthritis."[2]

WRITE:
for detailed information (clinical experience, side effects, precautions, etc.).

HOW SUPPLIED: *Bottles of 100 tablets.*

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DOSAGE: Adults, 2 tablets two or three times daily. After two or three months of therapy, the patient may no longer need the added benefit of aspirin. A maintenance regimen of Plaquenil sulfate alone (from 200 to 400 mg. daily) may then be substituted.

REFERENCES:

1. Scherbel, A. L.; Schuchter, S. L., and Harrison, J. W.: Cleveland Clin. Quart. 24:98, April, 1957.
2. Waine, Hans: Arthritis, rheumatoid, in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Co., 1959, p. 565.

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COMPONENT SOCIETY NOTES

Broward

Dr. Russell B. Carson of Fort Lauderdale, president of Blue Shield of Florida, Inc., presented guest speakers who discussed the physician's role in Blue Shield at the November meeting of the Broward County Medical Association held in the First National Bank Building at Fort Lauderdale.

DeSoto-Hardee-Glades

Dr. George A. Bishopric of Sarasota was guest speaker at the October meeting of the DeSoto-Hardee-Glades County Medical Society held at Arcadia. Dr. Bishopric's subject was the management of hypertension.

Duval

Dr. James H. Ferguson of Miami, Professor and Chairman of the Department of Obstetrics and Gynecology a the University of Miami School of Medicine, was principal speaker at the November meeting of the Duval County Medical Society. The title of Dr. Ferguson's address was "The Management of the Woman with the Positive Vaginal Cytology."

Hillsborough

Dr. J. Robert Snavely of Jackson, Miss., Chairman of the Department of Medicine at the University of Mississippi School of Medicine, was guest speaker at the November meeting of the Hillsborough County Medical Association. The title of Dr. Snavely's address was "Current Status of Hepatic Coma Problem."

Third Annual Conference
County Medical Society
Presidents and Secretaries
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Louis S. Goldstein Clinical Medicine 59:455 (1952) / Kass Archives of Internal Medicine Vol. 100, p. 709.

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- ✻ **Quiets the overactive cough reflex**
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COMPOSITION: Each tablet contains:

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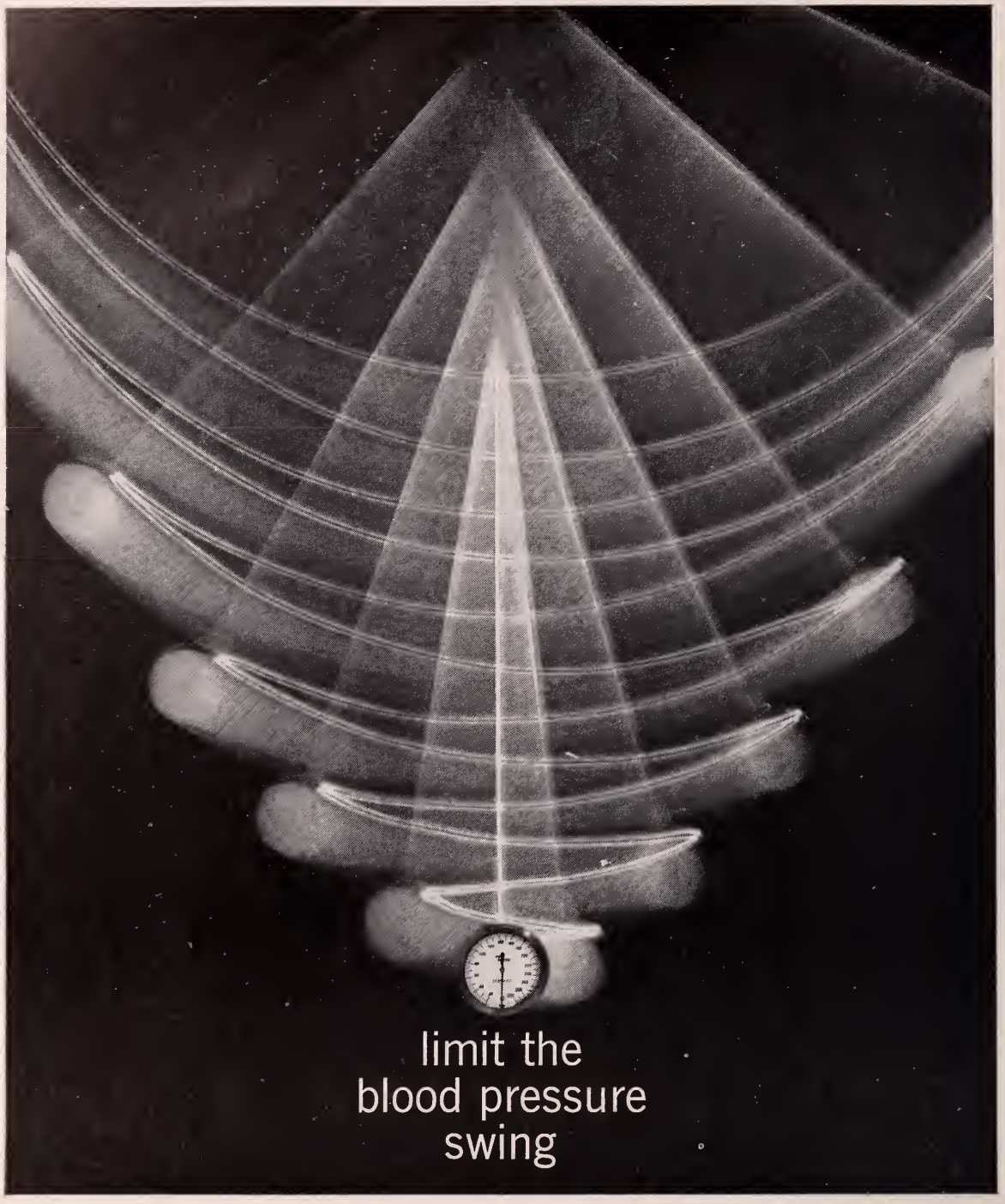
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OBITUARIES

Abram Fifield Thomas

Dr. Abram Fifield Thomas of Cocoa died on Sept. 7, 1960. He was 72 years of age.

Born in Cambridge, Mass., on June 3, 1888, Dr. Thomas attended the Cambridge public schools and the Cambridge Latin School. He received his college preparatory training at the Deichman School in Baltimore and then attended the Baltimore Medical College from 1907 to 1911. In 1912, he received the degree of Doctor of Medicine from the Chicago College of Medicine and Surgery. The following year, he served an internship at Cook County Hospital in Chicago. His fraternities were Chi Zeta Chi, Phi Rho Sigma and Theta Nu Epsilon.

Dr. Thomas entered the private practice of medicine in Florida, locating in Titusville in 1914. He practiced there for three years, serving as surgeon for the Florida East Coast Railway and examining surgeon for the United States Pension Bureau. In 1916 he moved to Newburyport, Mass., and practiced there until 1925, except for a year and a half spent in military service during World War I. He was commissioned a first lieutenant in the Medical Reserve Corps and served overseas with the Second Division, American Expeditionary Force, in 1918 and 1919. During his service he won the Croix de Guerre for bravery on the field and also received a special citation from the commander of the Second Division. In 1921 he was appointed city physician of Newburyport. In 1923 and also in 1945 he went to New York for postgraduate study at New York Polyclinic Medical School and Hospital. His specialty was obstetrics and gynecology.

In 1925, Dr. Thomas returned to Florida for four years and then again practiced in Massachusetts from 1929 to 1939. In 1940 he relocated in Florida at Cocoa, where he remained permanently thereafter. Following a heart attack in 1952, he was able to engage only in a limited office practice. In Newburyport he was a staff member of the Anna Jacques Hospital and the Worcester Memorial Hospital, and in Cocoa he was a member of the staff of the Eugene Wuesthoff Memorial Hospital at Rockledge. He was a particularly active Mason, holding various official posts, and was a charter member of the Bahia Shrine Temple in Orlando. He was also

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
JAMA
VOL. 174, NO. 5 OCTOBER 1, 1960
newest J.A.M.A. paper[1] reports
DBI
"oral therapy of choice"
in management of diabetes . . . from the mild stable adult to the severe labile juvenile

a member of the Elks Lodge and active in veterans' organizations.

Dr. Thomas was a member of the Brevard County Medical Society, serving as vice president in 1916 and as president in 1942. When practicing in Florida, he had held membership in the Florida Medical Association since 1914. In Massachusetts, he was affiliated with the Massachusetts Medical Society.

Surviving are the widow, the former Edna Gertrude McComas of Baltimore, and a daughter, Mildred H. Thomas Thistle, R.N., both of Cocoa.

Godfrey Luke Beaumont

Dr. Godfrey Luke Beaumont of Sebring died suddenly on Sept. 19, 1960, a few hours after resumption of his practice following a short vacation. He was 52 years of age.

Born in New Cumberland, W. Va., on June 16, 1908, Dr. Beaumont received his premedical training at Wittenberg College, where he was awarded the A.B. degree. In 1932, the M.D. degree was conferred upon him by the University of Pennsylvania School of Medicine. After completing an internship at Mercy Hospital in Pittsburgh, he engaged in the general practice of medicine in New Cumberland from 1933 through 1947, with service as a captain in the United States Army from 1942 to 1945.

In 1948, Dr. Beaumont came to Florida to reside and located in Sebring. He accepted the directorship of the Highlands-Hendry-Glades Health Departments and while serving in this capacity took a Public Health course at Tulane University School of Medicine from 1953 to 1954. In 1955, he entered the private practice of medicine in Sebring as a general practitioner and the following year took a short course in electrocardiography at Tulane. He was a member of the local posts of the American Legion and the Veterans of Foreign Wars. He was affiliated with the Masonic Lodge at New Cumberland and attended the First Presbyterian Church in Sebring.

Dr. Beaumont was a charter member of the Highlands County Medical Society and a former member of the DeSoto-Hardee-Highlands-Glades Medical Society. He held membership in the Florida Medical Association and also in the American Medical Association.

Surviving are the widow, Mrs. Mary Beaumont, and a daughter, Mrs. Charles Thomas, both

results of 104 "problem" diabetics treated with...

fair to excellent control in 91 of 104 diabetics (88%)
... achieved with DBI use alone or combined with exogenous insulin.

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1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1. 1960.

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Pectin	142.8 mg.
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hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

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of Sebring; a son, Robert Beaumont, of Miami; a sister, Miss Helene Beaumont, and two brothers, Dr. H. M. Beaumont and Dr. Frank Beaumont, all of Wellesville, Ohio; and one grandchild.

BIRTHS AND DEATHS

Births

Dr. and Mrs. James A. Whiteside of Coral Gables announce the birth of a son, Jonathan Lee, on October 1, 1960.

Dr. and Mrs. Marcus B. Bergh of Orange Park announce the birth of a daughter, Constance Ann, on September 23, 1960.

Dr. and Mrs. James A. Cranford Jr. of Jacksonville announce the birth of a daughter, Mary Elizabeth, on October 5, 1960.

Dr. and Mrs. David R. Moomaw of Jacksonville announce the birth of a daughter, Ellen Winter, on September 21, 1960.

Dr. and Mrs. Robert H. Still Jr. of Jacksonville announce the birth of a daughter, Jane Jay, on September 22, 1960.

Deaths — Members

Selman, Guy S., Washington, Ga.	May 6, 1960
Shevach, Randolph, Miami Beach	October 19, 1960

Deaths — Other Doctors

Sendker, Raymond W., St. Petersburg	March 1, 1960

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American Medical Education Foundation

Doctors:

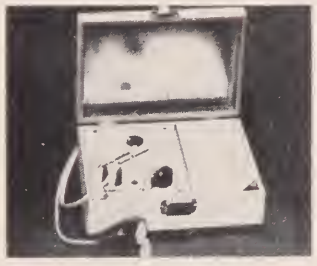
Now is the time to come to the aid of your medical school.

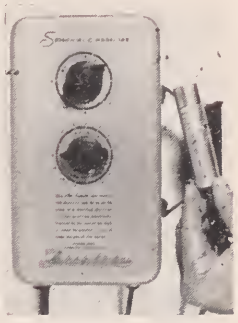
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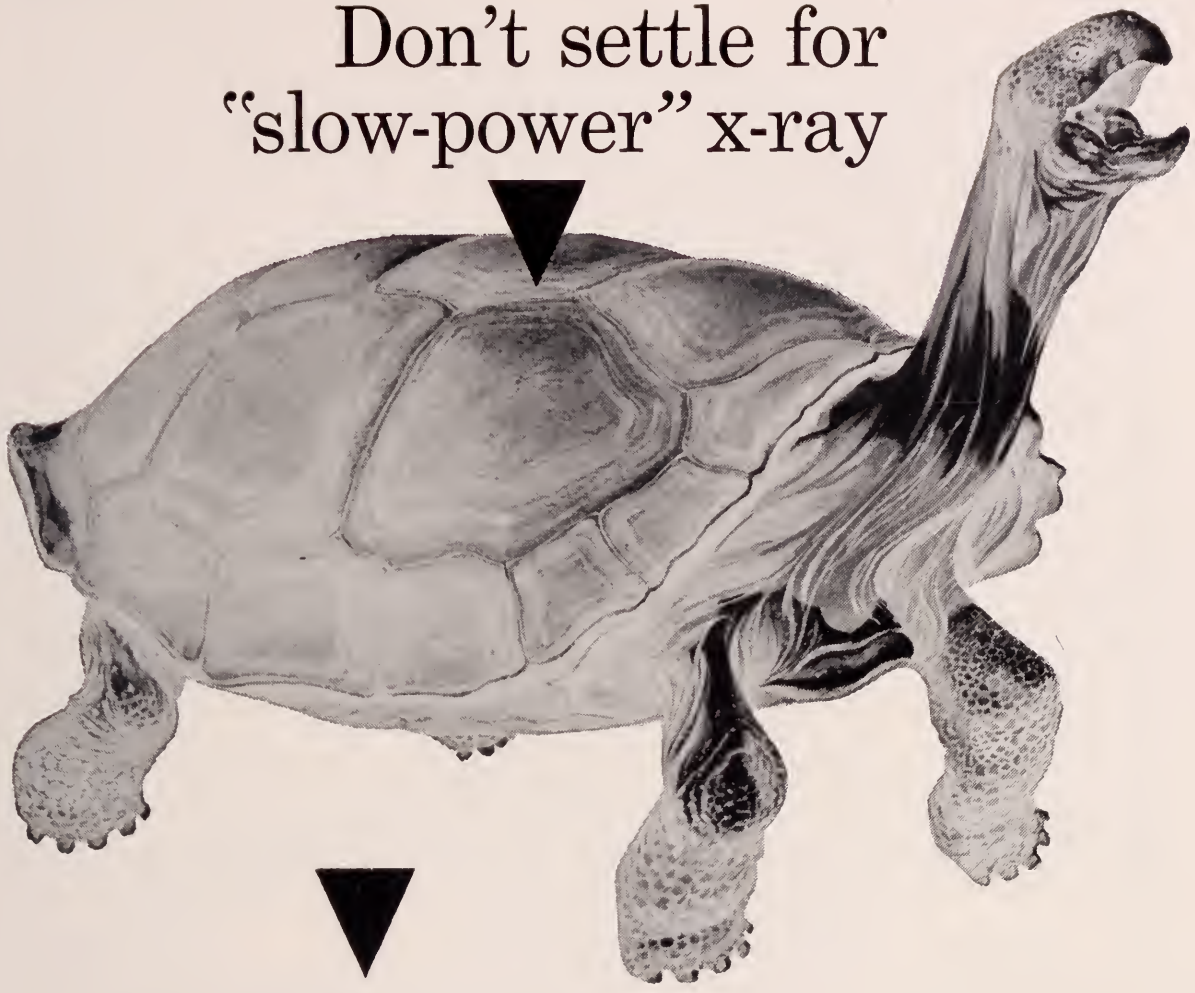
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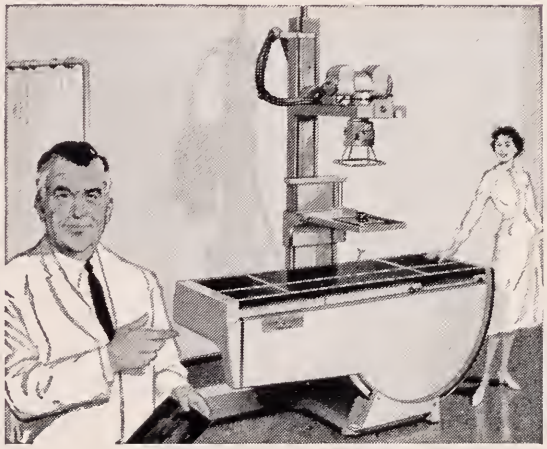
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FROM ABBOTT

To meet special nutritional needs of growing teenagers...

Filmtab® DAYTEENS
TRADEMARK

- RICH IN IRON, CALCIUM, VITAMINS—IMPORTANT FACTORS FOR THE GROWTH YEARS
- FILMTAB-COATED TO CUT SIZE AND ASSURE FULL POTENCY
- HANDSOME TABLE BOTTLES AT NO EXTRA COST (100-SIZE)
- ALSO SUPPLIED IN BOTTLES OF 250 AND 1000.

NOW, DAYTEENS JOINS THE COMPLETE LINE OF QUALITY VITAMINS BY ABBOTT:

FILMTAB
DAYALETS®
Table bottles of 100
Bottles of 50 and 250

FILMTAB
DAYALETS-M®
Apothecary bottles
of 100 and 250

Extra-potent maintenance formulas—ideal for the "nutritionally run-down"

FILMTAB
OPTILETS®

FILMTAB
OPTILETS-M®
Table bottles of
30 and 100
Bottles of 1000

Therapeutic formulas for more severe deficiencies—illness, infection, etc.

FILMTAB
SUR-BEX® with C
Table bottle of 60
Bottles of 100,
500 and 1000

Therapeutic formula of the essential B-complex plus C, for convalescence, stress, post-surgery, etc.

EACH DAYTEENS FILMTAB® REPRESENTS:

Vitamin A	(5000 units) 1.5 mg.
Vitamin D	(1000 units) 25 mcg.
Thiamine Mononitrate (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Nicotinamide	20 mg.
Pyridoxine Hydrochloride	0.5 mg.
Vitamin B_{12} (as cobalamin concentrate)	2 mcg.
Calcium Pantothenate	5 mg.
Ascorbic Acid (C)	50 mg.
Iron (as sulfate)	10 mg.
Copper (as sulfate)	0.15 mg.
Iodine (as calcium iodate)	0.1 mg.
Manganese (as sulfate)	0.05 mg.
Magnesium (as oxide)	0.15 mg.
Calcium (as phosphate)	250 mg.
Phosphorus (as calcium phosphate)	193 mg.

VITAMINS by ABBOTT

ABBOTT

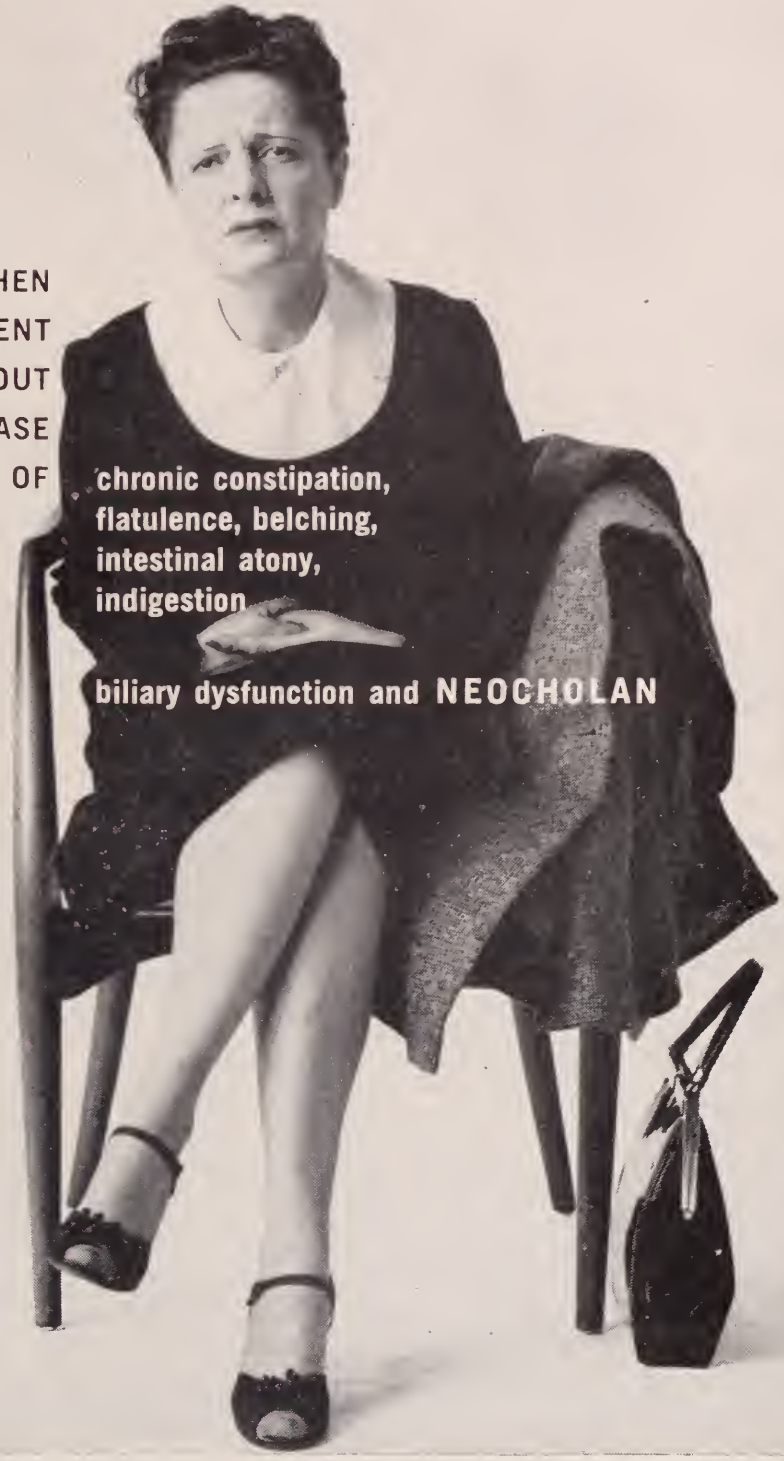
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WHEN
THE PATIENT
WITHOUT
ORGANIC DISEASE
COMPLAINS OF

chronic constipation,
flatulence, belching,
intestinal atony,
indigestion

CONSIDER

biliary dysfunction and NEOCHOLAN



NEOCHOLAN®

Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

PM

PITMAN-MOORE COMPANY
DIVISION OF ALLIED LABORATORIES, INC.
INDIANAPOLIS, INDIANA

Diet or Drugs?

In the long term control of serum cholesterol, dietary therapy can achieve the objective in the manner most closely approximating physiological norm.

The long term control of elevated serum cholesterol through changes in the dietary pattern of the patient puts nature's own process to work most effectively to achieve the objectives of treatment. Here are the beneficial features of dietary therapy:

Offers a solution to the related problems of obesity.

Involves little or no added expense to the patient.

May be used with complete safety.

Produces no adverse side effects.

Preferable for the long-term management of a chronic condition.

Brings about reduction of serum cholesterol through physiological processes, as yet not fully understood.

Does not usually generate new compounds in the blood, thus helping the doctor make a more accurate analysis of blood serum cholesterol.

Elevated serum cholesterol has now been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through the control of total calories and through the replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil.

An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St.

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



Wesson is poly-unsaturated . . . never hydrogenated

More acceptable to patients. Wesson is preferred for its supreme delicacy of flavor, increasing the palatability of food without adding flavor of its own.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of high iodine number are selected for Wesson, and no significant variations are permitted in the 22 exacting specifications required before bottling.

Economy. Wesson is consistently priced lower than the next largest seller.

New Orleans 12, La.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil...winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free



MODEL 100M MOBILE VISO-CARDIETTE

$895 delivered,
Continental U.S.A.

THIS IS THE NEWEST Sanborn electrocardiograph — complete with all accessories in a fully mobile, easy-to-roll cabinet version. A single Model 100M "Mobile Viso" can easily serve several locations within a clinic or hospital, and perfectly answers the need for instrument storage away from the point of use. The highly developed design of this modern instrument also provides fully diagnostic cardiograms at either of two chart speeds (25 and 50 mm/sec), sensitivity settings of ½, 1 or 2 times normal, fully automatic stylus stabilization during lead switching, pushbutton grounding, jacks for recording and monitoring non-ECG inputs in conjunction with other equipment. The cabinet is available in either handsome mahogany or exceptionally durable, stain-resistant plastic laminate.

The same basic instrument — with identical circuitry — is also manufactured as a *desk-top instrument*, designated *Model 100 Viso-Cardiette*. A third choice in Sanborn ECG'S is also offered, for the physician whose practice demands *maximum portability:* the 18-pound "briefcase" size *Model 300 Visette*. All are proven Sanborn electrocardiographs, reflecting more than four decades of experience in the manufacture of medical instrumentation.

MEDICAL DIVISION

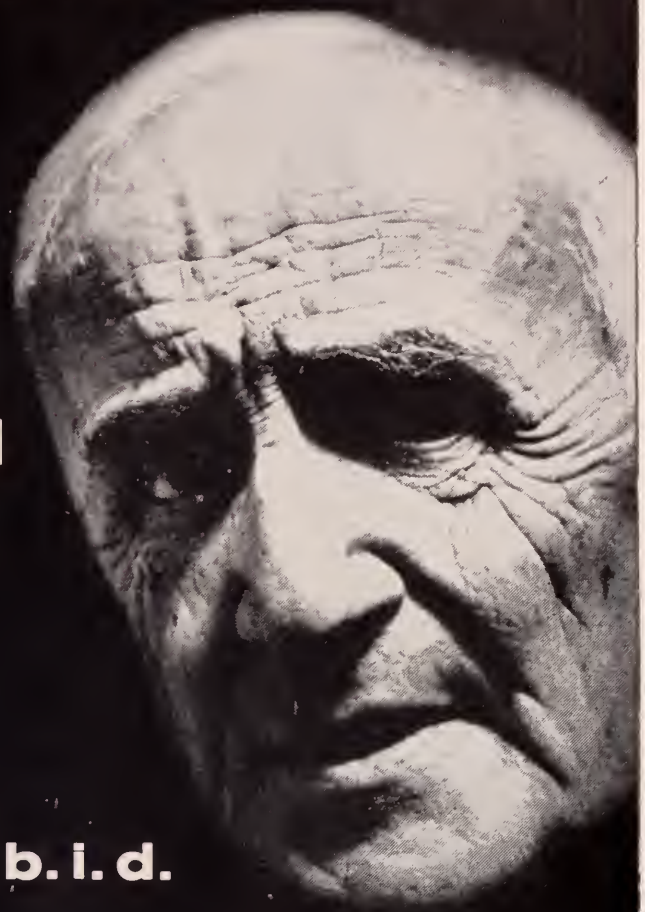
SANBORN COMPANY

175 WYMAN ST., WALTHAM 54, MASS.

MIAMI *Branch Office* 1545 S. W. 8th St.. Franklin 3-5493 & 3-5494

ST. PETERSBURG *Resident Representative*
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IN SENILE CONFUSION . . .



CONTINUOUS CEREBRAL OXYGENATION

WITH

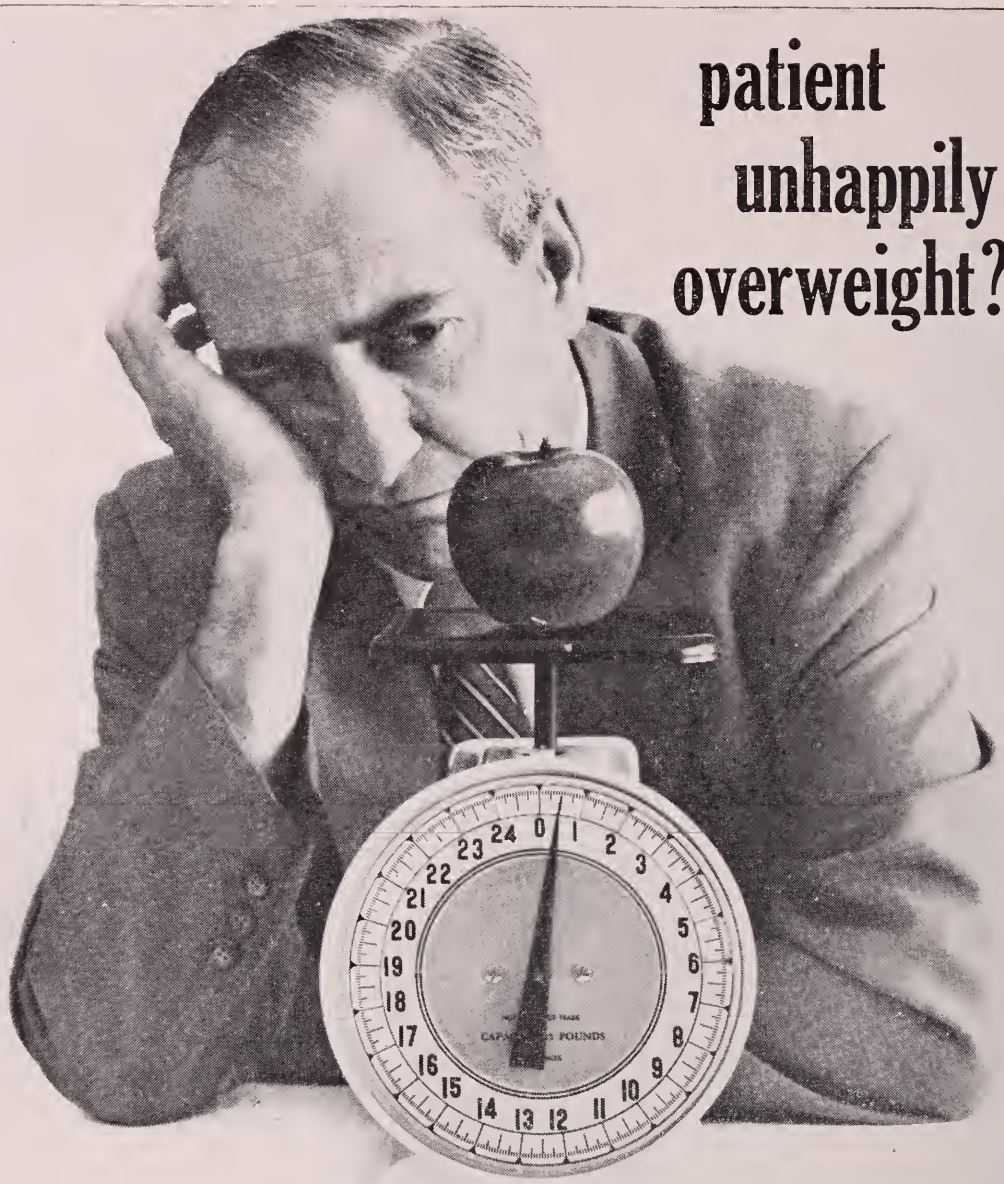
ONE

Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio



minimize care and eliminate despair with

'METHEDRINE'®

brand Methamphetamine Hydrochloride

Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

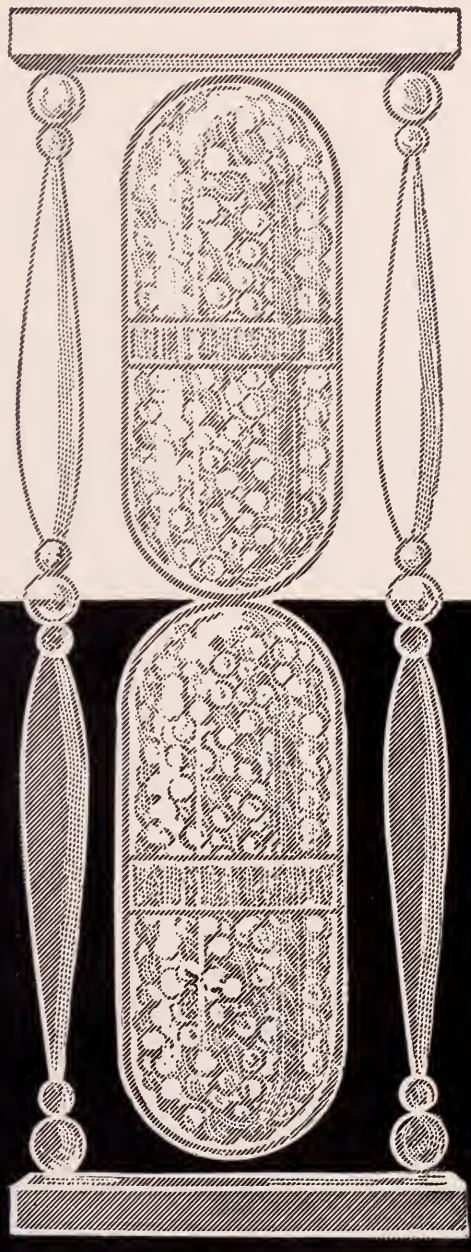
BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

True S-U-S-T-A-I-N-E-D Action in Steroid Therapy

PREDLON™
PELSULES*
prednisolone

Only 2 Pelsules Daily
Maintenance Dose

- Better therapeutic response
- Reduced daily dosage
- Fewer side effects
- Greater safety, convenience and economy



Now, for the first time, the benefits of steroid therapy are enhanced by sustained release PREDLON PELSULES.

USES: Rheumatoid arthritis, disseminated lupus erythematosus, allergic diseases, and other conditions where the use of steroids is indicated.

SUPPLY: PREDLON 5 mg. is available in bottles of 30 and 100 Pelsules.

DRUG Specialties INC.

Samples and Literature on request

WINSTON-SALEM 1, NORTH CAROLINA

*trademark for timed disintegration capsules

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY



Measured food, but not austere. Lemon juice salad dressing, bouillon, fruit ice add few carbohydrates, much appeal.

The secret of a successful diabetic diet is acceptance

Pleasing variety is possible in the diabetic's diet. With few exceptions, his menu can include satisfying amounts of most popular foods. Using exchange lists, imaginative meals can be planned that fit easily into your patient's daily life, gaining his fullest acceptance and co-operation.

Stews, chowders, soups, spaghetti and meat balls—many such tempting dishes can be adapted to a measured diet. Water-packed fruits, sugar-free preserves, sorbitol ice cream and other specialty foods replace forbidden sweets. Low-calorie wafers and raw vegetables can be included for party nibbling.



And with your approval, a glass of beer might be planned to add zest to your patient's diet.

Carbohydrate, 9.4 Gm; Protein, 0.8 Gm; Fat, 0 Gm; Calories, 104/8 oz. glass (Average of American Beers)

United States Brewers Foundation

If you'd like reprints of this and 11 other different diet menus for your patients, write United States Brewers Foundation, 535 Fifth Avenue, N.Y. 17, N.Y.

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.



STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

WINE...

Rx Now widely prescribed for the chronic invalid, the convalescent, the debilitated oldster

Physicians treating the aged and the convalescent have for generations been aware of the restorative power of wine. However, it remained for recent research* to more clearly define its clinical physiological action.

Wine Increases Appetite—Goetzl and co-workers[1] observed a profound stimulating effect on olfactory acuity and appetite, even in anorexia.

Wine Aids Gastric Digestion—Ogden and Southard[2] reported a significant increase in gastric secretion following ingestion of moderate amounts of table wine.

Wine Helps in Cardiology—Prudent quantities of wine are helpful[3] in counteracting depression, anxiety and discomfort in sufferers from heart and coronary disorders.

Wine—"*safest of all sedatives...*"[4]—A little Port or Sherry at bedtime offers a valuable relaxant to the insomniac and may obviate the need for drug-sedative medication.

In brief, wine taken with discretion adds greatly to the pleasures of the table, to physical comfort and to mental serenity in the aged, as well as in the chronic sufferer and the convalescent.

Research information on wine is available on request. Write for your copy of *"Uses of Wine in Medical Practice." Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Goetzl, F.R.: Permanente Found. M.Bull. 8:72 (April) 1950.
2. Ogden, E., and Southard, F.D., Jr.: Fed. Proceedings 5:77 (1946)
3. Brooks, H.: Med. J. & Rec. 127:199 (1928)
4. Haggord, H.W., and Jellinek, E.M.: Alcohol Explored, New York, Doubledoy, Doron, 1942.



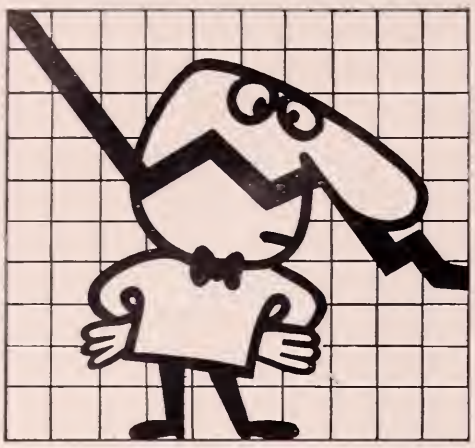
Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

D 27



A U. S. Senator recently said, "In investigating the pharmaceutical industry, we are investigating and inquiring into an industry that has won and which deserves public approval and confidence... It has been my judgment that the hearings to which I have referred, so far have been prejudiced and distorted." To paraphrase a political saying...

Let's Look At The Record On Drug Prices

In relation to "real income," drug prices have actually declined in recent years. At prevailing wages in 1929, it took 91 minutes of working time to pay for the average prescription. Only 86 minutes of labor paid for the average prescription in 1958. As one economist put it, "If the retail prices of drugs had risen as much as the consumer price index since 1939, it would cost the consumer at least an additional one billion dollars to buy the drug preparations now consumed." He goes on to compare the $19.02 per capita drug expenditure in 1958 with the $37.19 spent on tobacco products and $53.72 for alcoholic beverages.•When your patients inquire about the cost of medication, perhaps these facts will be helpful in explaining that today's prescription, averaging about $3.00, is a relatively modest investment in better health and a longer, more productive life.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

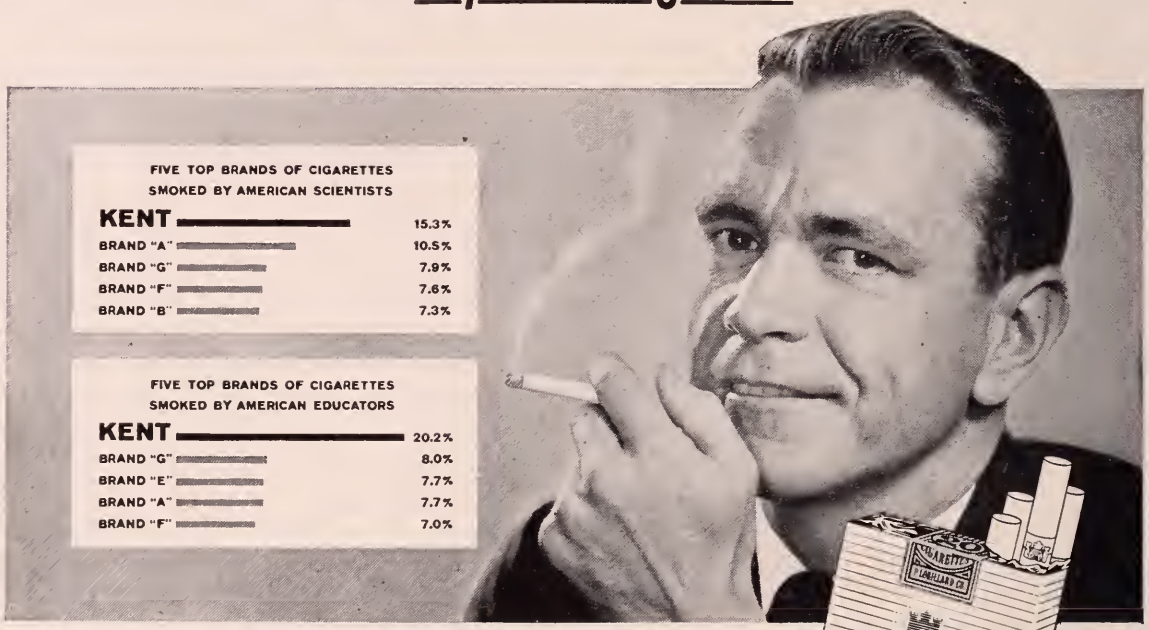
That's why the young lady's activities are of medical interest.

©Florida Citrus Commission, Lakeland, Florida

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.



KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY FIRST WITH THE FINEST CIGARETTES THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASE
WHICH INACTIVATES
OTHER PENICILLINS

Bristol™

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)
For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg. ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 1 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

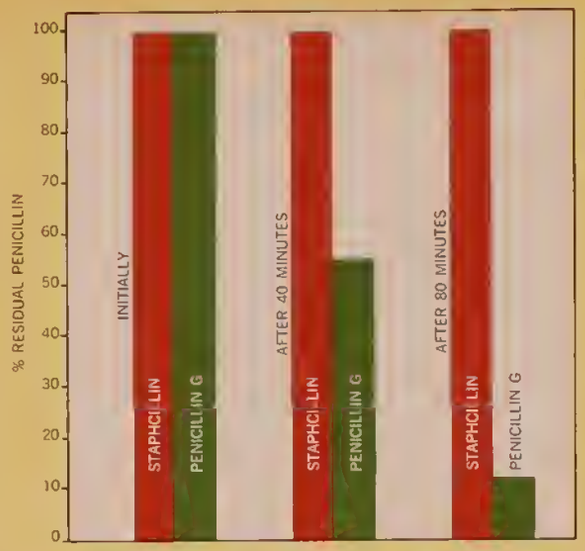
SUPPLY

List 79502 — 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company

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In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

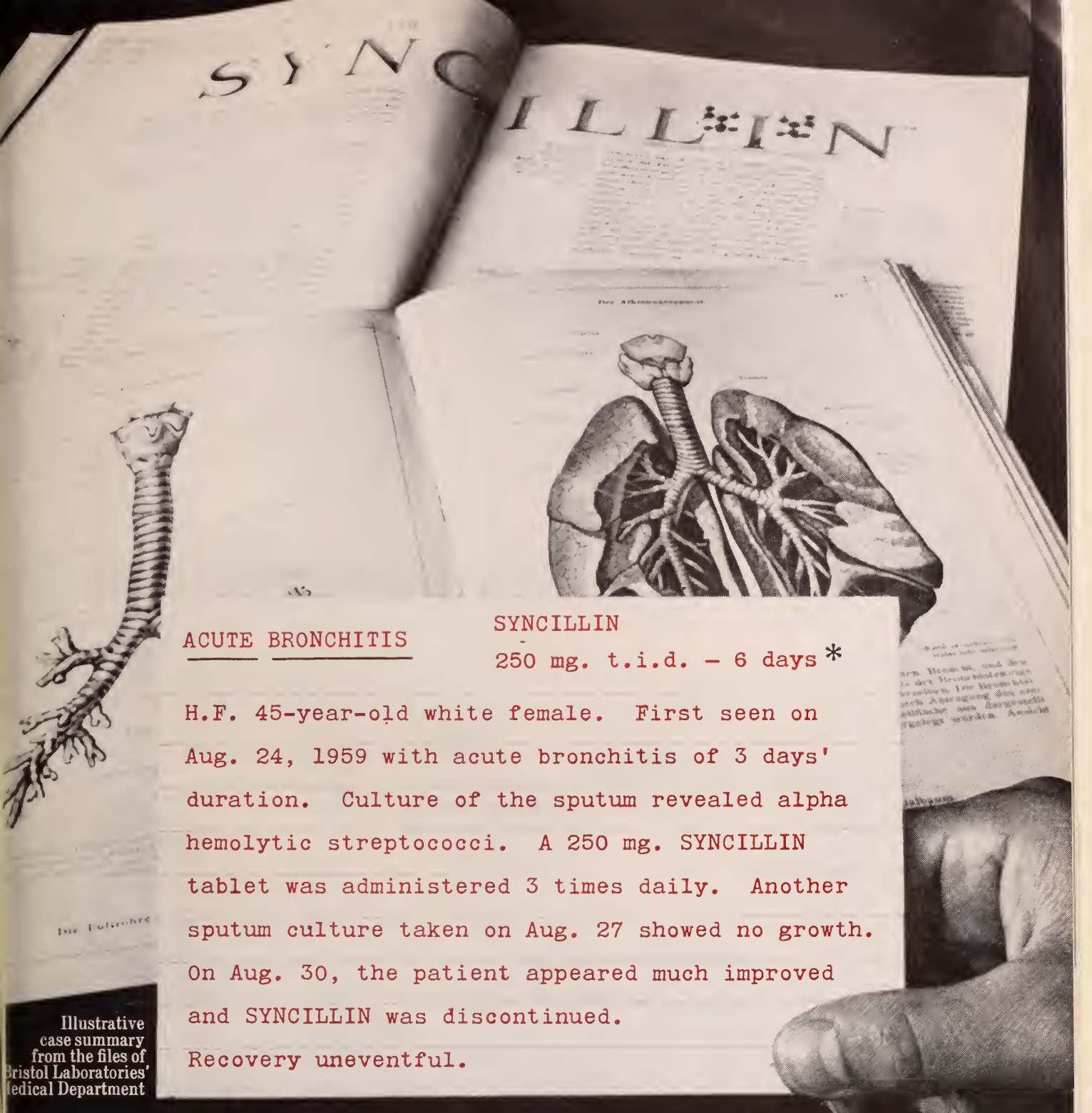
2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
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SYNCILLIN
250 mg. t.i.d. – 6 days *

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued. Recovery uneventful.

Illustrative case summary from the files of Bristol Laboratories' Medical Department

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(phenoxyethyl penicillin potassium)

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Syncillin Pediatric Drops—1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

*Streptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever and as prophylaxis against bacterial endocarditis in susceptible patients.

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

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acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

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No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

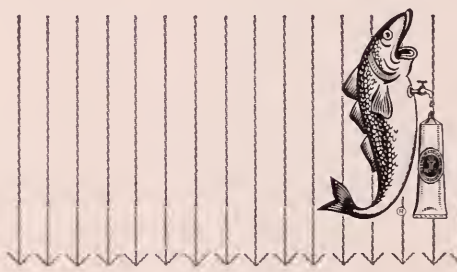
Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

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BOOK REVIEWS

Biopsy Manual. By James D. Hardy, M.D., James C. Griffin, Jr., M.D., and Jorge A. Rodriguez, M.D. Pp. 150. Illus. 54. Price, $6.50. Philadelphia, W. B. Saunders Company, 1959.

Their respect for the biopsy is acknowledged by the team of authors in this manual. They bring to the attention of the reader that a specimen for biopsy may be so inadequate or distorted that a wrong diagnosis can be made leading to possible death of the patient. Besides the possible errors, they tactfully describe the technic and complications involving biopsies. The material presented is nothing new to the senior medical student and intern because during their schooling they receive ample instruction from the various departments in regard to gathering tissue for biopsy. The manual is a review of the technics employed by the authors. They cover the field thoroughly and systematically and should be commended for such. The illustrations are drawings by one of the team and are expressibly simple and well done. Though the term "biopsy" is defined in the opening paragraph of the manual, it is used erroneously throughout the text. The operating physician does not "take a biopsy;" he merely removes the tissue for biopsy purposes. Biopsy is the examination of tissue from a living source. This is performed by the pathologist, grossly and microscopically. Regardless, the book is recommended for it is a good reference manual and will fit into the teaching program.

Clifford C. Snyder, M.D.

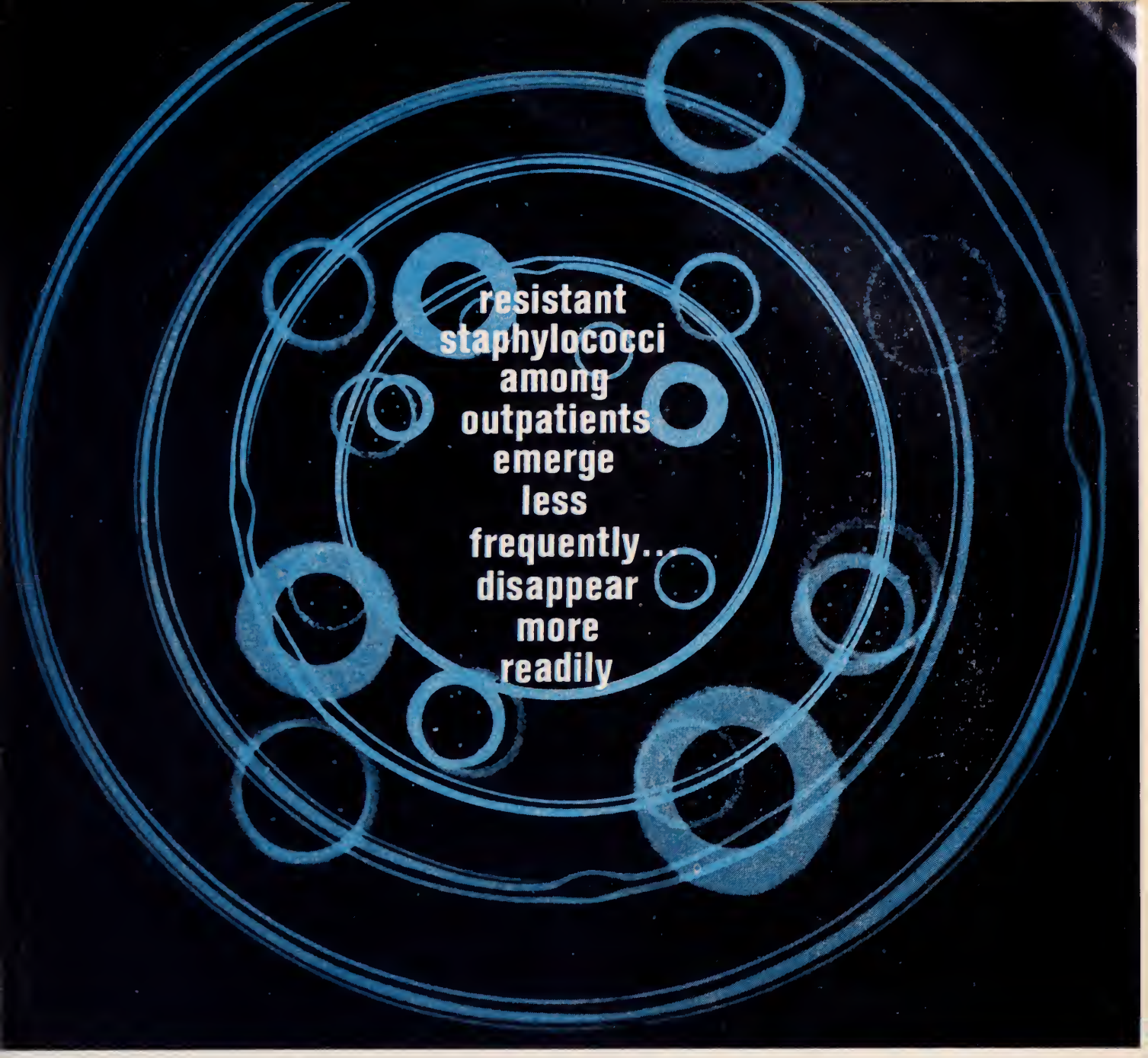
The Preparation of Medical Literature. By Louise Montgomery Cross, M.A. Pp. 451. Price, $10.00. Philadelphia, J. B. Lippincott Company, 1959.

The purpose of this book is to present in convenient form the practical technics of preparing medical literature for publication in journal or book form. The book is concerned strictly with technics, not with literary criticism. It is written for doctors, but may also be useful to certain others concerned with work on strictly medical literature. A convenient desk reference containing full details on the practical technics of preparing medical literature, this one-volume handbook is logically organized in the order of the various stages of preparation and contains all the information an author needs to initiate and carry through a writing project. It comprises both fundamental material and material of a more advanced and special nature. Drawing on her 25 years of experience as a professional medical writer, the author presents and comments on technics which are representative of generally accepted procedures rather than the preferences of specific individuals or groups. There is a chapter on Charts and Graphs by Shirley Baty, Medical Illustrator, The Memorial Center for Cancer and Allied Diseases.

Ciba Foundation Symposium on Carcinogenesis; Mechanisms of Action. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Maeve O'Connor, B.A. Pp. 336. Illus. 48. Price, $9.50. Boston, Little, Brown and Company, 1959.

Next to the understanding of the fundamental mechanisms of the living cell in health, we must learn how the diseased or abnormal cell functions. Twenty-nine researchers in this important field present about 40 separate reports and most of them participate in the subsequent discussions. No one with at least some interest in cancer will fail to learn many important new facts from this book. Some of the basic subjects discussed are: "Theories of Carcinogenesis," "Mechanisms of Carcinogenesis by Viruses," "The Mechanism of Hormonal Carcinogenesis,"

(Continued on page 739)



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*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960.

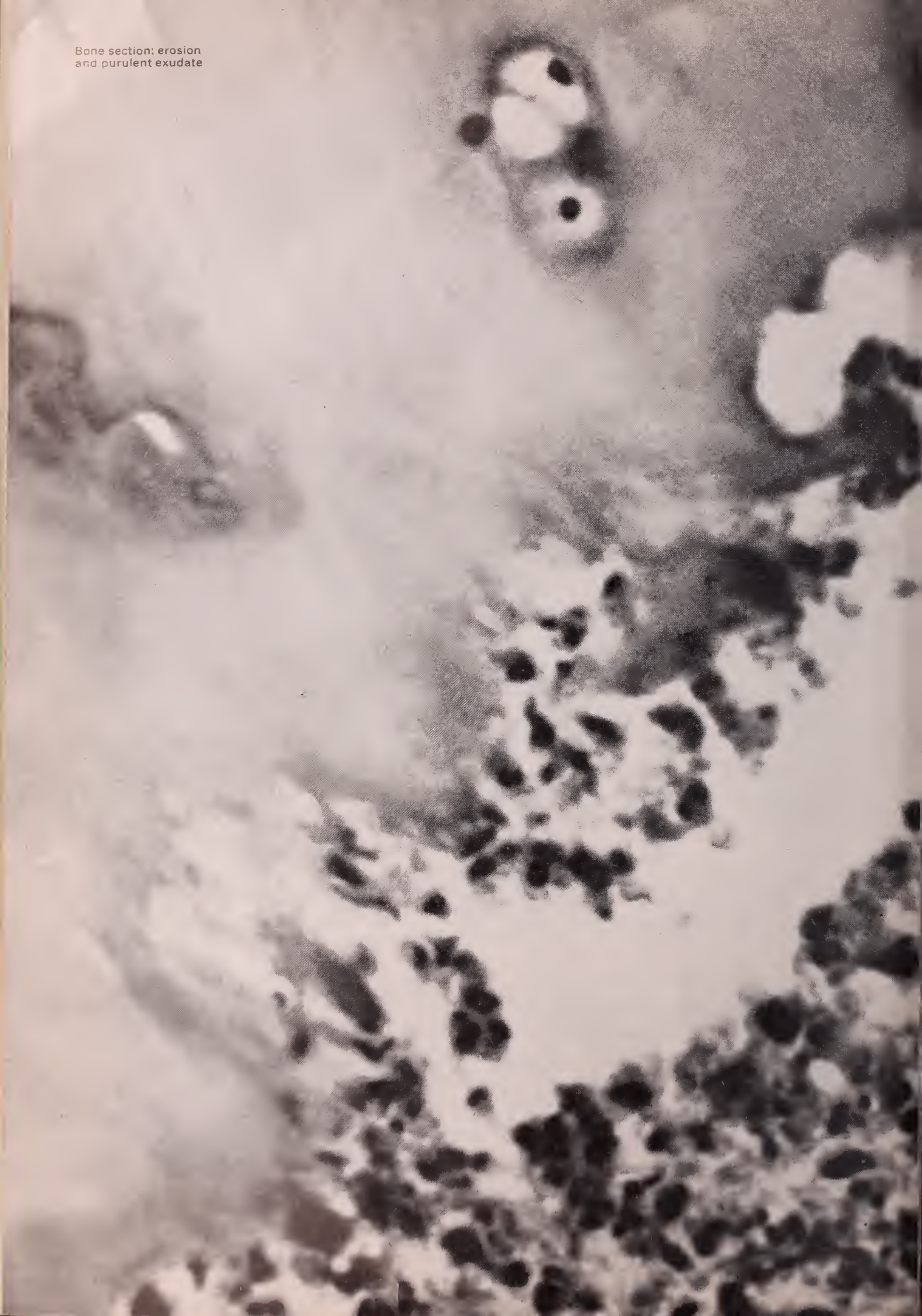
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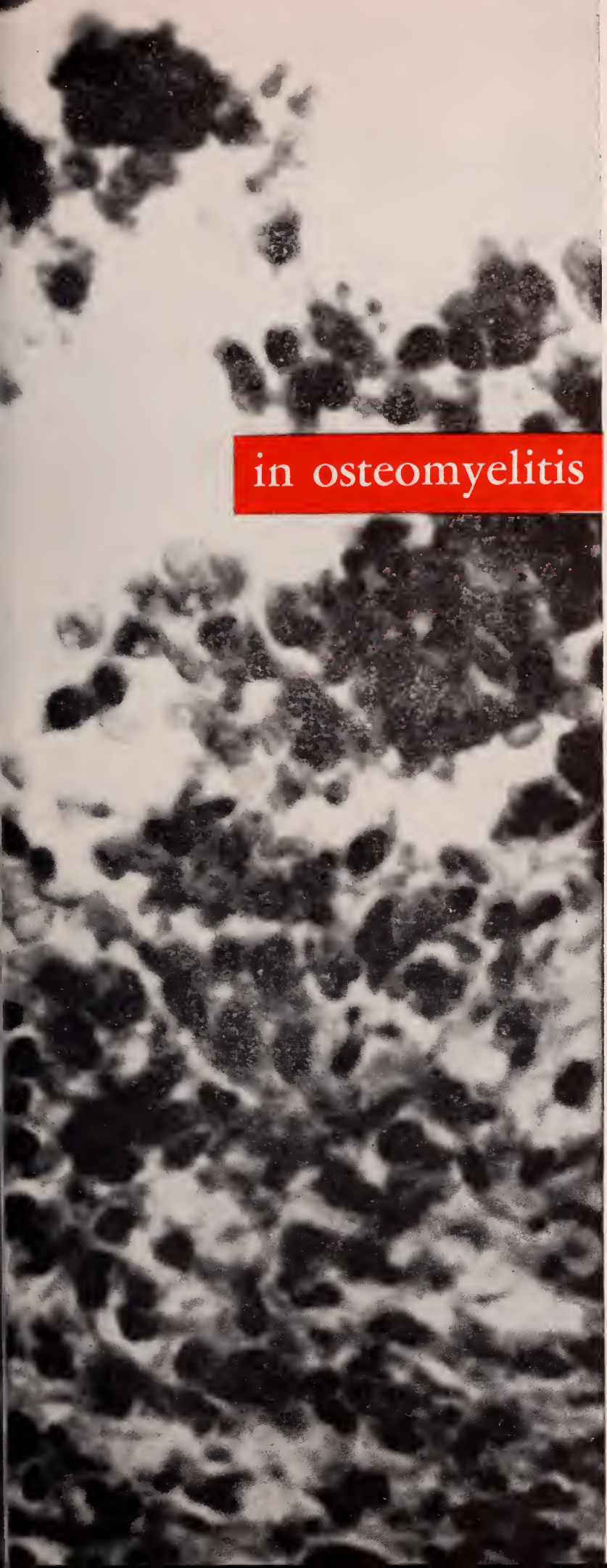
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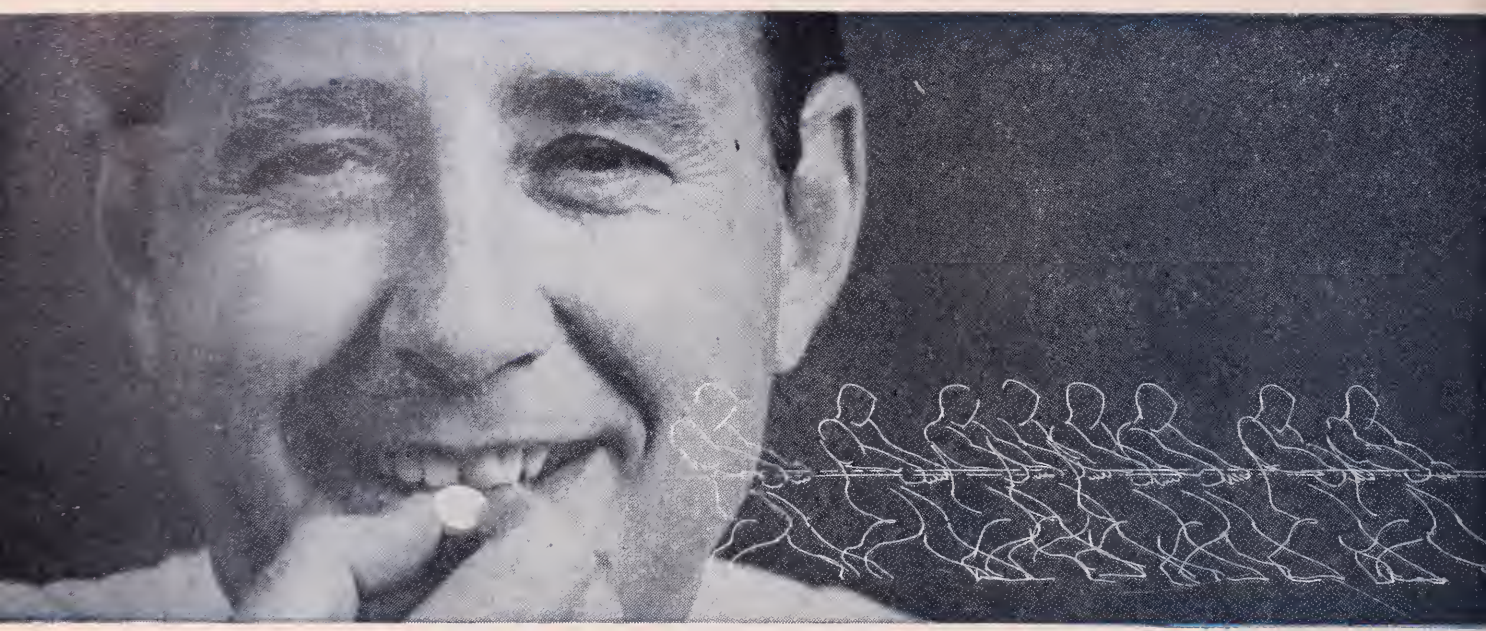
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(Continued from Page 734)

"Immunological Aspects of Cancer," and "The Possible Role of Metals and of Metal Chelation in the Carcinogenic Process." The usual excellent editing and profuse pertinent illustrations help even the uninitiated or the clinician not very familiar with the modern research tools and procedures to obtain clear understanding of these new facts and concepts. Like all other Ciba Foundation Symposia, this book is "a must" for every consulting library and should be read by everyone who has the slightest interest in cancer problems. C.P.L.

Living Beyond Your Heart Attack. By Eugene B. Mozes, M.D. Pp. 212. Price, $3.50. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959.

This book is intended for reading by patients who have suffered a coronary thrombosis and is filled with statistics and facts in easily readable form designed to correct many common misconceptions relating to this disease. It also has value as an antidote for the fear that commonly arises in patients who suffer this disease. The early portion of the book attempts to explain in lay language the pathology and pathophysiology of this condition. A description of current methods of diagnosis and therapy follows, and finally there is an extensive discussion of the role of diet, tobacco, alcohol, occupation, physical activity and emotions in the causation of coronary thrombosis. One might wish that the author had been less definite in some of his statements about treatment. For example, to this reviewer it seems that he has overemphasized the "arm-chair treatment" of the acute coronary thrombosis—a method which has not met with the widespread adoption he implies, and on the other hand he describes an unduly prolonged convalescent regimen. Unquestionably, the more studious coronary patient will find this book interesting and helpful. The physician who suggests this book to his patient would do well to scan it not only for the information it contains but also to be better prepared to answer his patient's subsequent questions.

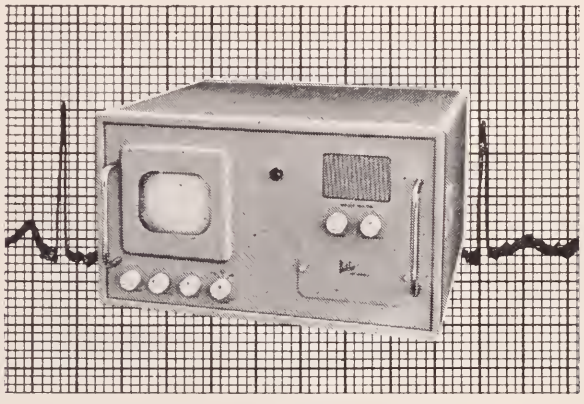
William M. Straight, M.D.

Ciba Foundation Colloquia on Ageing, Volume 5, The Lifespan of Animals. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 370. Illus. 58 and Cumulative Index to Volumes 1-5. Price, $9.50. Boston, Little, Brown and Company, 1959.

This is the fifth volume in a series by the CIBA Foundation reporting the proceedings of its colloquia on aging. It is not necessary to have reviewed the previous four volumes as the present one deals with specific subjects. There is a combined author-subject index to this and the previous four books for reference at the end of the subject matter. These texts make available the programs of international conferences on the problems of aging. The colloquium reported here presents the actuarial aspects of longevity and mortality and factors influencing them in the various living kingdoms. Among some of the interesting data found in the pages are that fishes are not subject to atherosclerosis whereas birds encounter it; a fish grows in size slower when placed in a small container of water; bees die of starvation in 48 to 72 hours because they do not store sugar; insect pathologists are rare and very expensive; a honeybee does not exist as an individual insect (hermit) but as a member of a colony; when the largest fish in a pond is removed, all the remaining "move up" one place; older trout do not produce as many eggs as younger ones, a finding not due to a sterility factor but instead due to the relationship of total body weight to gonad weight; and the longest-

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lived of fresh water fish is the sturgeon (151 years). A most interesting item observed in reading the text is that a fly may be kept alive indefinitely by merely changing the temperature of its environment. There are many intriguing little known particular facts discussed throughout the contents which will please the reader. The book is worth considering for one's library.

Clifford C. Snyder, M.D.

The Life Extension Foundation Guide to Better Health. By Harry J. Johnson, M.D. Pp. 220. Price, $4.95. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959.

As Medical Director of The Life Extension Examiners, a medical group specializing in preventive medicine for industry, insurance companies and private patients, the author has drawn upon over 3,000,000 examination reports for the writing of this helpful book. His purpose is to guide the reader in finding his own sense of well-being and so to bring him to his own highest efficiency level. He attributes to neglect of basic health care the arresting medical fact that most people live 25 to 50 per cent below their maximum efficiency level. With uncommon medical insight, he probes the vital health factors that directly affect a sense of well-being and presents up-to-the-minute inside medical facts on sleep, fatigue, tensions, food, vitamins, drugs, psychology, alcohol, smoking, the heart and much more. All information is presented simply, directly, honestly and factually, and nutshell summaries follow each chapter for the reader's own mental check-lists. Dr. Johnson, who is President of The Life Extension Foundation, believes that health is a positive condition, not the mere absence of disease, and offers this book as a guide along the path to longer and better life.

Pardon My Sneeze. *The Story of Allergy.* By Milton Millman, M.D. Pp. 215. Illustrated. Price, $4.00. San Diego, Calif., Kuchirka Books, 1960.

This second edition of this book has been brought up to date and enlarged. The first section covers the general field of allergy and makes clear the importance of cooperation between the patient and his physician. The second section is intended primarily for allergic patients and the families who care for them so that they may better understand the disorder and its management. The third part of the book is designed to help the allergic patient and his family remove all causative allergenic agents from his environment. In this section, the sources of contacts of various allergens and methods of their elimination are described. The last of the 22 chapters presents sample recipes which may be of benefit to the allergic patient. The book tells the story of allergy in a practical readable manner.

Textbook of Otolaryngology. By David D. DeWeese, M.D., and William H. Saunders, M.D. Pp. 464. Illus. 354. Price $8.75. St. Louis, The C. V. Mosby Company, 1960.

Everyday problems involving the ear, nose and throat are dealt with in this text with clarity so that the student of medicine should profit by reading its pages. There is enough information regarding newer techniques to make the contents enjoyable also to the general practitioner. The index of chapters is simply outlined and covers the subject from the physical examination and the anatomy to the various therapies administered for the diseases and conditions described. The volume is beautifully edited and produced. The only criticism is not one of intention and that is that there are so very many similar texts on the book market today.

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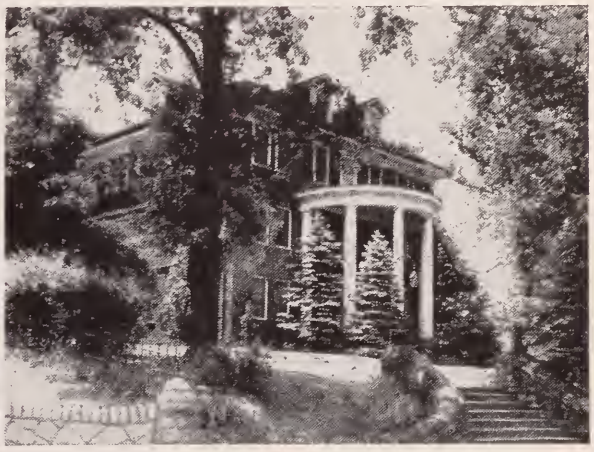
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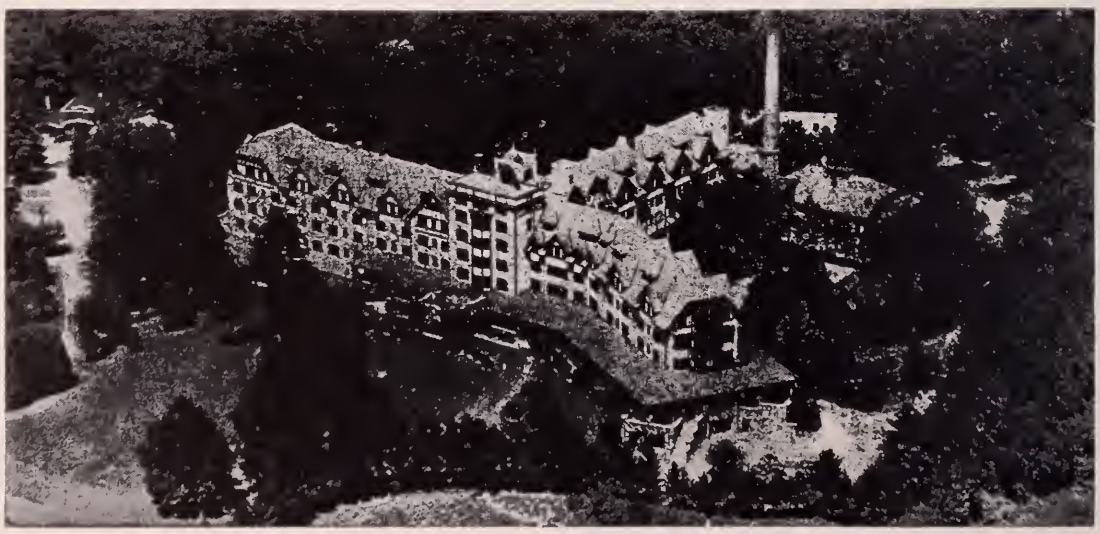
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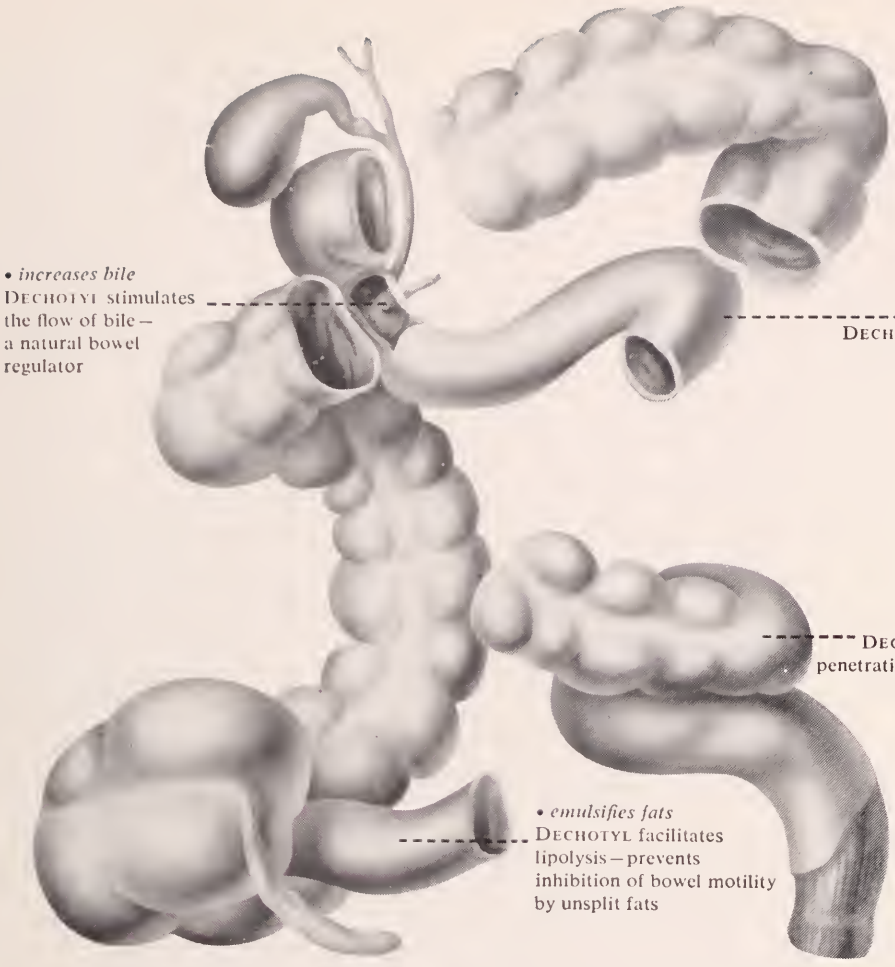
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Alachua	Eugene H. Cummings, Gainesville	Richard E. Perry, Gainesville	2nd Tues.		85
* *Bradford, Gilchrist, Union*					
Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
Brevard	Cyrus E. Warden, Melbourne	Spencer C. Manrodt, Melbourne	1st Tues.	2	74
Broward	Burns A. Dobbins Jr., Ft. Lauderdale	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	42	267
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.		7
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	132	1048
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	357
Clay	Marcus B. Bergh, Orange Park	John M. Malone, Green Cove Springs			10
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	12
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	264
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	4	35
* *Sumter*					
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		38
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	6	78
Madison	Julian M. Durant, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	6
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Marion	Herbert M. Webb Jr., Ocala	Keith H. Knorr, Ocala	3rd Tues.	1	33
* *Levy*					
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Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	36	235
* *Osceola*					
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Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	8	89
Seminole	Edwin Epstein, Sanford	Robert J. Smith, Sanford	2nd Tues.	1	18
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* *Flagler*					
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Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	3	4
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